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RACHEL GREGORY BSc (Hons) PGDip

**BORDERLINE PERSONALITY DISORDER AND HELPFUL  
SERVICE RELATIONSHIPS: A GROUNDED THEORY STUDY**

Section A: How mental healthcare services relate to people diagnosed  
with borderline personality disorder: A literature review

Word count: 5491

Section B: Borderline personality disorder and helpful service  
relationships: A grounded theory study

Word count: 7999

SectionC: Critical Appraisal

Word count: 4992

Overall Word Count: 18,482

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ  
Church University for the degree of Doctor of Clinical Psychology

JULY 2010

SALOMONS  
CANTERBURY CHRIST CHURCH UNIVERSITY

### **ACKNOWLEDGEMENTS**

I would like to express my sincere gratitude to all the participants who generously gave their time and who spoke so openly about their experiences. Thank you so much for providing so many valuable narratives for this research. I was genuinely touched by your experiences and felt privileged to hear about your lives in such detail.

Thank you to my supervisors, Dr John McGowan, and Dr Ruth Chester, for their support throughout this process. I truly appreciated all the advice and enthusiasm they provided with this research project. In particular, many thanks to John for seeing me through this project and supporting me through the more troubled times. I would also like to thank Dr Chris Gilmore and Mr Roger Davies who kindly helped with recruiting participants.

Obviously not forgetting my long-suffering family and friends who have been neglected whilst I've been so involved in my research but whom without their support this would not have been possible. A special thank you to you all, particularly to my parents Mr Andrew Gregory and Mrs Glenis Clifford who have always supported me throughout my education and career.

## SUMMARY OF PORTFOLIO

**Section A:** Critically reviews the literature pertinent to how services are helpful for people diagnosed with borderline personality disorder. This includes service-user research and evidence based on clinicians experiences. Relevant theories are discussed and the gap in the current evidence base is provided.

**Section B:** Presents the findings of a grounded theory study investigating how services relate to people with borderline personality disorder (BPD). Individual semi-structured interviews were conducted with eight clinicians and eight service-users diagnosed with BPD. The findings suggest that psychological principles (e.g. validation and acceptance) are helpful since they promote a secure attachment between the individual diagnosed with BPD and the relating service/s. A model is provided which suggests that services vary in attachment styles from disorganised and unhelpful service relationships through to secure and helpful attachments. Clinical implications and future research suggestions are described.

**Section C:** Critically appraises the research project and provides reflections about the research process and how the researcher felt when conducting this research project.

**CONTENTS**

<b><u>SECTION A: LITERATURE REVIEW</u></b>	<b>Page</b>
<b>Abstract</b>	<b>10</b>
<b>Introduction</b>	<b>11</b>
<b>Borderline personality disorder</b>	<b>11</b>
<b>Prevalence of BPD</b>	<b>13</b>
<b>Treatability of BPD</b>	<b>14</b>
<b>Recent NHS policies for managing BPD</b>	<b>15</b>
<b>Unhelpful mental healthcare services</b>	<b>17</b>
<b>„Illness“ based approaches</b>	<b>17</b>
<b>The “revolving door” phenomenon</b>	<b>18</b>
<b>Suicide Risk and responsibility</b>	<b>19</b>
<b>Power, Abuse and conflict</b>	<b>20</b>
<b>Services perpetuating damaging attachments</b>	
<b>Helpful psychological models</b>	<b>23</b>
<b>Dialectical behaviour therapy model</b>	<b>23</b>
<b>Mentalization Based therapy model</b>	<b>24</b>
<b>Therapeutic communities model</b>	<b>25</b>
<b>Evidence-base for service-user views</b>	<b>27</b>
<b>Evidence Base for clinician views</b>	<b>28</b>
<b>Summary and rationale for research</b>	<b>30</b>
<b>References</b>	<b>33</b>

**SECTION B: EMPIRICAL PAPER**

	<b>Page</b>
<b>Abstract</b>	<b>45</b>
<b>Introduction</b>	<b>46</b>
<b>Recent NHS policies for managing BPD</b>	<b>47</b>
<b>Unhelpful mental healthcare services</b>	<b>47</b>
<b>Helpful psychological models</b>	<b>49</b>
<b>Evidence-base for service-user views</b>	<b>52</b>
<b>Evidence Base for clinician views</b>	<b>52</b>
<b>Research rationale</b>	<b>54</b>
<b>Research aims</b>	<b>54</b>
<b>Method</b>	<b>55</b>
<b>Design overview</b>	<b>55</b>
<b>Participants</b>	<b>56</b>
<b>Procedure</b>	<b>57</b>
<b>Data analysis</b>	<b>58</b>
<b>Methodological rigour</b>	<b>59</b>
<b>Results</b>	<b>59</b>
<b>Participant characteristics</b>	<b>59</b>
<b>Healthy relationships with services (categories 1-3)</b>	<b>61</b>
<b>Unhealthy relationships with services (categories 4-7)</b>	<b>67</b>
<b>A psychological model of service relationships</b>	<b>74</b>
<b>Discussion</b>	<b>75</b>
<b>Key findings and theoretical implications</b>	<b>76</b>
<b>Study limitations</b>	<b>80</b>
<b>Clinical implications</b>	<b>81</b>
<b>References</b>	<b>84</b>

**SECTION C: CRITICAL APPRAISAL****Page**

<b>Summary of research findings</b>	<b>92</b>
<b>Methodological issues</b>	<b>93</b>
<b>Rationale for grounded theory approach</b>	<b>93</b>
<b>Epistemological position</b>	<b>94</b>
<b>The sample</b>	<b>94</b>
<b>The interviews</b>	<b>97</b>
<b>The analysis</b>	<b>98</b>
<b>Quality assurance methods</b>	<b>99</b>
<b>Ethical considerations</b>	<b>100</b>
<b>Theoretical considerations</b>	<b>101</b>
<b>Clinical implications</b>	<b>103</b>
<b>Future research</b>	<b>105</b>
<b>Personal reflections</b>	<b>107</b>
<b>Considering a topic area</b>	<b>107</b>
<b>Awareness of researcher biasing</b>	<b>108</b>
<b>Reflections of the findings</b>	<b>109</b>
<b>References</b>	<b>111</b>

**LIST OF TABLES AND FIGURES****Page****SECTION B**

<b>1. Table 1: Service-user participant characteristics</b>	<b>59</b>
<b>2. Table 2: Clinician participant characteristics</b>	<b>60</b>
<b>3. Figure 1: Model illustrating how services are helpful for people diagnosed with BPD</b>	<b>74</b>

**SECTION D: APPENDICES****Page**

<b>Appendix 1: Research &amp; development approval letter</b>	<b>116</b>
<b>Appendix 2: Research &amp; development approval letter</b>	<b>117</b>
<b>Appendix 3: Approval letter from the chair of ethics panel with full approval</b>	<b>118</b>
<b>Appendix 4: Participant invitation letter for clinicians</b>	<b>119</b>
<b>Appendix 5: Participant information sheets for Clinicians</b>	<b>120</b>
<b>Appendix 6: Participant invitation letter for service users</b>	<b>122</b>
<b>Appendix 7: Participant information sheets for service users</b>	<b>123</b>
<b>Appendix 8: Participant consent form</b>	<b>125</b>
<b>Appendix 9: Clinician interview schedule</b>	<b>126</b>
<b>Appendix 10: Service-user interview schedule</b>	<b>129</b>
<b>Appendix 11: Table of clinician and service-user categories and subcategories</b>	<b>132</b>
<b>Appendix 12: Example transcript</b>	<b>133</b>
<b>Appendix 13: Category development for clinicians and service-users combine</b>	<b>148</b>
<b>Appendix 14: Categories, sub categories, open codes &amp; quotes for clinicians</b>	<b>150</b>
<b>Appendix 15: Categories, sub categories, open codes, &amp; quotes for service-users</b>	<b>166</b>
<b>Appendix 16: Abridged research diary</b>	<b>180</b>
<b>Appendix 17: Excerpts of memos of coding process</b>	<b>191</b>
<b>Appendix 18: Feedback sent to participants</b>	<b>194</b>
<b>Appendix 19: Summary of feedback sent to ethics panel</b>	<b>199</b>
<b>Appendix 20: Journal of Personality Disorders, notes for contributors</b>	<b>201</b>
<b>Appendix 21: Independent review approval letter</b>	<b>202</b>



## **INDEPENDENT RESEACH PROJECT**

### **Section A**

How services relate to people diagnosed with borderline  
personality disorder.

A systematic review of the literature.

**RACHEL GREGORY BSc (Hons) PGDip**

Word count:

5491 (plus 278 additional words)

A thesis submitted in partial fulfilment of the requirements of  
Canterbury Christ Church University for the degree of  
Doctorate of Clinical Psychology

JULY 2010

SALOMONS  
CANTERBURY CHRIST CHURCH UNIVERSITY

### **Abstract**

The following literature review examines the research evidence regarding how mental healthcare services are helpful for people diagnosed with borderline personality disorder (BPD). Specifically, the psychological processes involved in helpful service relationships for people with BPD are explored. Definitions of BPD are discussed and various psychological theories and models of working with such clients are presented. Particular attention is paid to various mental healthcare settings including community mental health teams, in-patient wards, and more specialist models such as the therapeutic communities approach. Relevant NHS policies pertinent to this area of research will also be examined for themes around helpful psychological processes. The paper concludes with a rationale of why it is important to qualitatively investigate how mental health services might be helpful for people diagnosed with BPD.

## Introduction

The following literature review examines the evidence relating to borderline personality disorder and associated mental healthcare service relationships. Relevant literature was identified using the electronic databases PsycINFO, Medline, SAGE, CINAHL, Science Direct, Web of Science, and the Cochrane library (no specified earliest start date until June 2010). The main search terms included borderline personality disorder/BPD, personality disorder, helpful/unhelpful, attachment, service relationships, dialectical behaviour therapy, mentalization based therapy, therapeutic communities, community mental health/teams, inpatient, in/dependency, risk, responsibility, service-users and clinicians. These search terms were entered alone and in combination with each other. Additional searches were undertaken using Google Scholar, contacting authors and a manual search of references cited in key articles and books was conducted.

Firstly, a definition of borderline personality disorder will be given and its prevalence and treatability explored. Recommendations from relevant NHS policies will follow from this and an in-depth examination of the literature on unhelpful and helpful service relationships will be presented.

## Borderline Personality Disorder

*“Personality disorder appears to be an enduring pejorative judgement, rather than a clinical diagnosis.”* (Lewis & Appleby, 1988, p.44).

„Personality disorder“ is defined by the American Diagnostic and Statistical Manual of Mental Disorders (DSM IV, American Psychiatric Association, 2000) as an “enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the

individual's culture" (p.629). These difficulties are considered both pervasive and inflexible, usually manifesting in adolescence and leading to considerable distress and impairment.

Haigh (2006) commented that „personality disorder“ is one of the most controversial labels within mental healthcare services. Not only is there considerable controversy and disagreement surrounding their definition and classification (Perris, 1999) but as Warne and McAndrew (2007) suggested, this diagnosis often leads to negative stereotyping and discriminatory practices. Snowden and Kane (2003) also found evidence that this diagnosis is often unreliable whilst Kendell (2002) found that people with personality disorders are frequently denied therapeutic treatment, resulting in therapeutic neglect (Gunn & Robertson, 1976). As Lewis and Appleby (1988) asserted, individuals with this diagnosis are often “denied the benefits of being regarded as ill but also the privilege of being regarded as „normal“” (p.48).

Borderline personality disorder (BPD) is a subtype of personality disorder that as Allen (2004) commented, holds similarly pejorative undertones. Also referred to as „emotionally unstable borderline type“ (International Classification of Diseases; ICD-10, World Health Organisation, 1992), it is defined as “a pervasive pattern of instability in interpersonal relationships, self-image, affects, and marked impulsivity” by the DSM-IV (American Psychiatric Association, 1994, p.629).

Relational difficulties are a key trait of BPD and this often includes frantically avoiding abandonment and becoming involved in unstable and intense relationships. Individuals with BPD often have intense and extreme emotions and may self-harm or become suicidal at times of distress. Insecure attachment difficulties are characteristic of this client group and as Bateman and Fonagy (2008) theorised, this is particularly when the primary caregiver has been abusive or neglectful. They explained that as infants people with insecure

attachments will show exaggerated reactions to the main caregiver such as “clinging, fearfulness of dependency needs, terror at abandonment and constant monitoring of the caregiver” (p.34). As Crittenden (1997) further elaborated, these individuals may develop BPD as adults and become deeply ambivalent and fearful of close relationships. Furthermore, Gunderson (1996) theorised that individuals with BPD often cannot tolerate aloneness nor can they be too intimate as a direct consequence of early attachment failures. In particular, many people with BPD report being abused or neglected as children, which may lead to such attachment difficulties. As Sabo (1997) found empirically, as many as 70 to 80% of individuals with BPD describe a history of severe childhood trauma, especially childhood abuse (Bernstein, 2002).

It is recognised that people with BPD are generally the most help-seeking, attract the most attention, and often present themselves to services when they are in crisis. They often threaten self-harm or aggression, consequently evoking high levels of anxiety in others. More encouragingly, Bateman and Fonagy (2008) have found from clinical experience that people with this diagnosis often have a desire to change and are possibly more amenable to interventions than other personality disorder subtype diagnoses.

### **Prevalence of BPD**

“This diagnosis is often given to non-compliant, female, self-harming service-users who are seen as ‘trouble’” (Allen, 2004, p. 135).

Within the United Kingdom, Bateman and Fonagy (2003) estimate that 2% of adults are diagnosed with BPD. However, Keown, Holloway and Kuipers, (2002) found a much higher prevalence rate of personality disorders within mental healthcare services. As the National Institute of Clinical Excellence (NICE, 2009) identified, many studies report in excess of 50% of this population have personality disorders with BPD being the most

prevalent outside of forensic settings. As Nehls (1998) estimated, up to a quarter of service-users would qualify for a diagnosis of BPD in general mental healthcare settings.

Palmer et al. (2006) found that this imposes significant costs for the National Health Service (NHS). Moran (2002) also identified that these costs should include emergency services treatment and management of co-morbid features (such as depression or substance abuse) for a more accurate picture.

### **Treatability of BPD**

“When treatment options are not effective, ‘misfits’ might be erroneously labelled as ‘treatment resistant.’” (Diamond & Factor, 1994, p.197)

Lewis and Appleby (1988) commented that the diagnosis of BPD tends to be given to „the patients“ psychiatrists „dislike“ (p.44). It carries the greatest stigma of all mental health problems (Department of Health; DoH, 2003) and whilst this attitude is slowly changing, Haigh (2006) has identified through clinical experience that many clinicians continue to believe little can be done to help people with this diagnosis. As Dawson (1996) found in a qualitative study, people with BPD are commonly viewed as less likely to change whilst Huband and Tantam’s (1999) qualitative study found that inpatient nurses view them as less deserving of care than people with other mental health problems. Beck Freeman and Davis (2007) have also commented that many psychological therapists continue to believe these individuals are untreatable.

Allen (2004) asserted that the diagnosis of BPD implies a fixed and global deficiency of the person’s whole self. This in itself holds a pessimistic, pathologising and stigmatising prognosis since the diagnosis suggests people cannot change. Clinicians are often aware of this stigma and do not want to communicate this diagnosis with service-users since they fear

further stigmatising people. In doing so, Allen (2004) theorised that clinicians may inadvertently collude with the system further excluding people from treatment.

Markham and Trower (2003) among others, commented that fear around helping people with this diagnosis is maintained because clinicians experience more negative emotion towards these individuals. This is substantiated by the use of labels such as „demanding“, „manipulative“, and „attention-seeking“ whilst self-harm is often viewed as a rejection of professional care. Allen (2004) claimed this is especially true when teams lack specialist understanding or have case loads too large to enable them to effectively manage these clients.

Although there continues to be significant stigma surrounding this diagnosis, clinicians are becoming better informed about treatment options. In particular, recent NHS policies and empirical evidence have contributed to a more positive reframing of this diagnosis and have tackled negative assumptions around un-treatability and stigma.

Relevant recent NHS policies will be discussed first followed by a review of the research evidence concerning how services help people with a diagnosis of BPD.

### **Recent NHS Policies for Managing BPD**

The Department of Health's (DoH, 2003) document „Personality disorder: No longer a diagnosis of exclusion“, was published to reduce exclusion from mental healthcare services for people with personality disorders. They found that people with this diagnosis were often stigmatised and treated at the margins of NHS services (e.g. accident and emergency services). It was suggested that this creates “revolving-door” service-users, with multiple admissions, inadequate care planning and infrequent follow-up procedures. Recommendations from this policy included the provision of specialist multi-disciplinary

personality disorder teams, improved staff selection, supervision, education, and training, and out of hours /crisis services to be set up in mental healthcare services.

The '*Personality Disorder Capabilities Framework*' (National Institute for Mental Health in England; NIMHE, 2003) then followed this report and provided a framework to support the development of necessary skills. This included training practitioners to promote social functioning and psychological well-being, assessing and managing risk, and structuring a clear pathway towards management.

More recently, the National Institute for Clinical Excellence (NICE, 2009) published clinical guidelines for the management of BPD. The emphasis was for a person-centred collaborative care approach, building optimistic and trusting relationships, and involving carers and family where appropriate. Specialist personality disorder and crisis services were recommended and the guidelines warned against poly-medication. When inpatient stays were necessary, NICE (2009) recommended short and preferably planned admissions.

Both Bateman and Tyrer (2004) and NICE (2009) reviewed the research evidence for psychological therapies. Although neither of these reports advocated any one particular approach they both suggested that therapy should be well structured, explicit, clearly focussed, and theoretically coherent. They commented on the importance of the treatment alliance and having well-managed endings. They also recommended that brief psychological interventions should not be conducted with this client group.

Although these policies provide a useful framework for clinicians, they fail to fully examine how services relate helpfully to people with BPD.



## **Defining Helpful Service Relationships**

Most research literature defines helpful services and interventions as those that reduce distressing symptoms, promote recovery and help the individual live a more fulfilling life (e.g. Anthony, 1993). For individuals diagnosed with BPD, the service relationship is possibly an important aspect of treatment and recovery. Researchers such as Paris (2008) suggested helpful service relationships include services that promote independence, personal responsibility, and do not reinforce dangerous behaviours (e.g. self-harm).

A consideration of the empirical research comparing unhelpful and helpful service relationships is presented as found in the following literature search.

### **Unhelpful mental healthcare services**

Most theoretical understanding about unhelpful services for people diagnosed with BPD has come from clinical assumptions rather than empirical evidence. This includes themes around medical approaches, dependency, responsibility, power and abuse.

#### **„Illness“ Based Approaches**

Burns (2004) commented that based on clinical experience, most people with BPD tend to be treated within community mental health teams (CMHTs) where an „illness“-based approach dominates. As Koekkoek, Van Meijel, Schene, and Hutschemaekers (2009) found in their recent study, these teams provide a “safety net” for many individuals but this approach is less helpful for people with BPD where medicalising relational difficulties was viewed as unhelpful by clinicians. As Sampson (2006) further suggested, most CMHTs tend to follow a medical treatment model. For example, the focus on diagnosis, symptom management, medication, and curing of presenting issues limits opportunities to understand

the root causes of problems. Nehls (1998) argued that this approach is more concerned with case management and reactive crisis care rather than intensive psychotherapy. By patching up symptoms and medicalising relational difficulties, Hodges (2003) theorised that recovery is hindered since these symptoms are likely to re-appear during a crisis. He also suggested that this approach pathologises and stigmatises people whilst Haigh (2002) empirically reported that service-users preferred less emphasis on symptoms and diagnosis and more about acceptance, attachment and validation.

### **The “Revolving Door” Phenomenon**

Overly-dependent relationships with services are commonly agreed as problematic with this client group. However, such dependency may be a complex interaction between the provision of sub-therapeutic support and the attachment difficulties inherent in the individual. As Koekkoek, et al. (2009) found, people with BPD tend to receive inadequate therapeutic help. When people with this diagnosis enter a crisis additional help is provided temporarily through hospitalisation and medication. Once the symptoms subside, Sampson (2006) theorised that the threat of discharge may trigger unmanageable feelings of rejection and abandonment. This may lead to a suicide attempt as a way of re-establishing a relationship but also increases dependency when services provide more care.

As Houck (1976) suggested, “the hospital meets the individual’s needs for love, dependency, and reassurance” (p. 28) rather than aiming for the individual to become more independent. This viewpoint persists today. For example, Paris (2008) has argued from clinical experience that contrary to clinicians’ beliefs, hospitalisation rarely provides a form of safety and only increases dependency on services. Friedman (2008) agreed and suggested that in hospital individuals form a false sense of security and do not learn resilience outside of the hospital environment. As Nehls (1993) theorised, “the short-term risks associated with

not using the hospital must be weighed against the long-term risks of continuing a cycle of recurrent, unproductive or even harmful hospitalisations” (p. 170).

### **Suicide Risk and Responsibility**

A pattern of chronic suicidality is characteristic of BPD. Paris (2004) has empirically found that one in ten suicidal BPD service-users will eventually commit suicide; this has been termed a “suicidal career” by Maris, Berman, and Silverman (2000). Paris (2004) further theorised that these behaviours are generally a communication to others that they are distressed since they struggle to ask for help constructively. Campling (2001) suggested early experience of chaotic, abusive attachments means people with BPD lack basic trust and may behave in this way to access help.

When services become reactive to these imposed risks Campling (1999) argued that clinicians often take responsibility for service-users behaviours. She theorised that professionals may fear being held accountable so they enforce restrictive and coercive interventions (e.g. psychiatric admissions) to manage their own anxieties. McGowan (2008) agreed, when services behave like this they fulfil the individual’s need for care and security but prevent the individual from making a choice to “get well” (Williams, 1998, p.173).

Nehls (2000) found empirically that risk-averse services may limit treatment options and stunt creativity towards alternative treatments. Furthermore, Sampson (2006) theorised that this ultimately increases the dependency that professionals aim to avoid whilst inadvertently reinforcing dangerous behaviours. As Linehan (1993) commented from clinical experience, self-harm is rewarded with more nursing care whilst the hospital provides what Paris (2004) calls, “little more than a suicide watch” (p.224). Indeed, as NIMHE (2003) identified, there is a skills deficit in hospital settings that may contribute to this.

### **Power, Abuse and Conflict**

Another difficulty often found in mental healthcare services is the issue of power and conflict. Burns (2006) has found through experience that although the multidisciplinary team (MDT) approach found in mental healthcare settings (e.g. CMHTs) is helpful for providing access to a variety of perspectives and services, it also often leads to conflicts within teams. Onyett (1998) theorised that MDTs often experience inter-disciplinary rivalry that has negative consequences for people with BPD. In particular, Burns (2006) commented that projection<sup>1</sup> and splitting<sup>2</sup> may occur which can lead to polarised views in staff teams that can exacerbate conflicts. Rathbone and Campling (2005) acknowledged that this is particularly apparent on inpatient wards where they had experienced people with BPD idealising some staff whilst viewing others as hostile, controlling, or abusive. They theorised that when staff are polarised in this way, inconsistent responses might be given, hindering helpful treatment.

Brown (1992) identified that the authoritarian, hierarchical context of mental healthcare treatment replicates abusive situations from people's pasts. Nehls (1998) agreed that mental healthcare services are often conflicting, fragmented, and overstretched. They tend to be unplanned, inconsistent and repeatedly going through structural changes which are unhelpful. She also theorised that this potentially replicates the fragmentation, inconsistency, untrustworthiness and intrusion of earlier childhood attachment experiences; replicating past abusive situations and fostering insecure attachments. Furthermore, Allen (2004) commented from clinical experience that people with BPD are often blamed and punished when the service feels they have nothing to offer or when the team is engaged in their own disagreements; unfairly blaming the individual for splitting the team.

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<sup>1</sup> Placing one person's own unacceptable feelings onto another (Valliant, 1993)

<sup>2</sup> Viewing people in extremes as either 'all good' or 'all bad' (Valliant, 1993)

Allen (2004) theorised that repeated patterns of powerlessness might manifest in patterns that appear „manipulative“ as opposed to survival strategies. When this occurs, Rathbone and Campling (2005) suggested that clinicians may struggle to cope with the demands and anxieties such clients present with, resulting in the attachment relationship suffering.

### **Services perpetuating insecure attachments**

It is commonly agreed that people with BPD have developed insecure or disorganised attachment styles; fearing the loss of a relationship and oscillating between care-seeking and angry withdrawal (Fonagy, 2001). Goodwin (2003) theorised that this possibly has repercussions for services since insecure attachment relationships often develop between services and the individual with BPD.

Holmes (2003) empirically found that some services form insecure attachments to individuals but this can be very subtle and needs further researching. A grounded theory study by Fallon (2001) found that service-users felt mental healthcare services contributed to ambivalent attachment to services. For example, they described some services as being uncaring, untrusting, and inconsistent; characteristic of insecure relationships.

The in-patient ward environment is often viewed as particularly un-containing and frightening by both staff and people with BPD. A lack of experienced staff often contributes to high levels of anxiety and defensiveness but also fosters insecure attachments with this client group. Gunderson (1996) found through clinical experience that high levels of clinician anxieties, constant changes in professionals, and inconsistencies in dependable key staff re-awaken feelings of rejection, loss and abandonment whilst promoting insecure attachments. In particular, Haigh (2002) theorised that when this occurs individuals

perceived as being more powerful, such as consultant psychiatrists, are experienced as inconsistent parental figures when they are less available.

Hinshelwood (1999) speculated that clinicians may retreat emotionally under the guise of „scientific attitude“ as a means of distancing themselves emotionally and physically from the difficult emotions experienced when working with such clients. He suggested that this leaves service-users feeling abandoned, rejected and unworthy of care. Bardaracco (1992) further suggested that when clinicians feel distanced from their secure role, service-users may become the receptacle of their clinician’s own unbearable feelings. Aviram, Brodsky and Stanley (2006) theorised that this might leave clients feeling rejected, with clinicians inadvertently perpetuating self-harming behaviours or withdrawal from treatment.

Another difficulty is the issue around discharging people with BPD. When the individual fears abandonment, a suicide attempt is usually a last-ditch attempt at re-establishing a relationship (Fonagy, 2001). As Bateman and Fonagy (2003) explained, the child’s experience may have been that “only extreme behaviours would change the adult’s behaviour” (p.208). When services react coercively to this, they may repeat abusive situations from the individual’s past whereby a disorganised attachment to services may result.

As these various models suggested, insecure attachment styles such as dependency, rejection, and abandonment are acknowledged as unhelpful ways of mental healthcare services relating to people with BPD. However, what does the current literature suggest are helpful ways of relating?

### **Helpful psychological models**

There is increasing research evidence (e.g. NICE, 2009) that psychological models specifically designed for BPD are therapeutically helpful. This includes dialectical behaviour therapy (DBT), mentalization based therapy (MBT), and the therapeutic communities (TC) approaches. However, what psychological processes do each of these models suggest as helpful?

#### **Dialectical Behaviour Therapy Model**

First developed by Linehan (1993), DBT is a form of cognitive-behavioural therapy originally designed to treat women diagnosed with BPD who self-harmed. It directly targets suicidal ideation, treatment-interfering behaviours (e.g. non-attendance), and other dangerous behaviours (e.g. drug abuse) within individual therapy and skills-based training groups. DBT aims to help individuals regulate emotions and tolerate distress by reality-testing and using mindfulness skills (Linehan, 1993).

As Linehan and Dimeff (2001) suggested, the therapist uses dialectical strategies which aim to promote acceptance and validation of clients' feelings whilst suggesting alternative coping strategies. According to Grossmann and Grossman (2005) this helps foster a secure attachment experience within the therapeutic relationship. In particular, DBT promotes consistency through a case management framework that supports secure attachment formation. Swenson, Witterholt and Bohus (2007) empirically found that this reduces inconsistent reinforcement of maladaptive behaviours and promotes shared understanding and a sense of safety. By adopting this stance, Allen (2004) theorised that the unhelpful dependency and invalidation often found in mental healthcare settings is discouraged.

Hodgetts, Wright, and Gough (2007) interviewed service-users from a DBT programme and identified the therapeutic relationship and collaborative working as important aspects of DBT. Group work was also considered helpful in providing a sense of shared identity. Cunningham, Wolbert, and Lillie (2004) also interviewed service-users and found that they valued therapeutic relationships that were non-judgemental and validating. They also reported that therapists needed to be appropriately challenging, less hierarchical, and able to empower people to take more responsibility.

### **Mentalization Based Therapy Model**

MBT is a form of psychotherapy specifically designed for individuals with BPD (Bateman & Fonagy, 2004). Central to this model is the concept that people with this diagnosis fail to develop a mentalization capacity within the context of attachment relationships. As Bateman and Fonagy (2008) theorised, people with BPD are often unable to recognise, tolerate, and respond to their own, and others' mental states, often misinterpreting their own thoughts, feelings and behaviours as well as those of others. Through a safe and secure attachment to the therapist, Fonagy (2001) asserted that self-reflection of mental states can be achieved with the clinician mirroring the individual's affect and exploring the mind of the other.

Bateman and Fonagy (2003) have empirically found that there is often an absence of effective mirroring of affect in the caregiver of infants who go on to develop BPD. As a way of coping, Bateman and Fonagy (2006) theorised that people decouple their mind from other minds, relying on earlier psychological mechanisms to organise experience. By developing the capacity to mentalize, Bateman and Fonagy (2006) suggested individuals will improve their ability to regulate emotions as well as building and maintaining healthy relationships.



At the same time the individual is encouraged to mentalize, experience, and confront negative affect helping form more secure attachments in relationships.

This model suggests that having more than one therapist who shares an understanding of this model may foster the mentalizing abilities of the individual. When conflict arises with one therapist or within a group, another therapist can help the individual consider alternative hypotheses about the first therapist's beliefs and intentions which will help maintain a more secure attachment to the service.

Bateman & Fonagy (2008) have found from clinical experience that this form of therapy needs a consistent approach, linking ideas between sessions. They found that this is especially important because people with BPD struggle to hold in mind different representations and affects at any one time. This could be relevant to mental healthcare services (e.g. CMHTs) where contradictory views are often held by clinicians that might be confusing and de-stabilising for this client group. According to this model, it is also important that clinicians fulfil their promises because people with BPD often struggle to trust others. Consequently, if false promises are made, even if based on therapeutic optimism, this will affect the attachment relationship when these promises are broken.

### **Therapeutic Communities Model**

The TC approach promotes people's well-being through social relationships, daily structure and various group therapies. Norton and Dolan (1995) explained that the environment is structured, predictable, with clear rules that allow for flexible responses to each individual. Collective and collaborative decision making and voting procedures are often used whilst a flattened hierarchy and equality is promoted. Rawlinson (1999) empirically found that group psychotherapy is particularly helpful since a strong sense of belonging is promoted. According to Campling (2001) having supportive relationships is also

helpful for fostering secure attachments that can withstand high levels of aggression and risk. As Kennard and Haigh (2009) theorised, it is the community itself that is the primary therapeutic instrument.

According to the TC model, the paternalistic relationship style of CMHTs and inpatient services is not helpful. Hinshelwood (1999) theorised that more responsibility should be given to the individual and that clinicians need to believe that individuals can function in helpful ways (Kennedy, 1987). Doing so allows clinicians to take appropriate risks and Campling and Dixon-Lodge (1999) asserted that this helps the individual cope better. As Campling (2001) suggested, mutual dependence, responsibility, and empowerment are helpful within the TC.

In a study by Hafner and Holme (1996) service-users were found to value therapy groups, living closely with others within the community. Morant and King (2003) also found that service-users felt it was difficult to return to CMHTs after being seen in a TC. Service-users considered CMHTs to be too passive and encouraged individuals to adopt overly-dependent roles. This contrasted against the responsibility people took for their own care in the therapeutic communities. For example, in TCs unhelpful dependency is reduced by focussing less on the individual and more on the group.

To summarise, within the NHS, specialist MBT and DBT services exist but on a limited scale. However, MBT is gaining popularity since it is backed by useful research evidence and is relatively cheap to use. There are very few TCs within the NHS possibly because it is an expensive treatment model and this is suggested by the recent closure of the Henderson hospital.

As these models suggest, certain psychological principles and therapeutic approaches are helpful for people with BPD. However, what do clinicians and service-users value as helpful? The evidence from service-users and clinicians is presented.

### **Evidence-base for service-user views**

There is limited research evidence based on service-users' views and most studies only describe how services are helpful rather than considering psychological processes involved in helpful service relationships.

Haigh (2002) interviewed 14 service-users and found common themes around people valuing therapeutic choice, having trusting and reliable relationships, clear communication, and having a shared understanding. Continuity of care was found to be important whilst the label „personality disorder“ was felt to be problematic with clinicians often holding unhelpful prejudices.

A large qualitative study was also employed by Crawford et al. (2007). They interviewed 190 people with personality disorders and found that service-users often felt rejected or that they had been treated badly by services. They identified that services needed to be welcoming, flexible and accessible but felt the rules were sometimes too rigid and that ideally, there should be some way of retaining a link with services after completing treatment. With regards to specialist services, there was a strong sense of belonging through shared experiences and these services were viewed as being more optimistic.

In Crawford et al.'s (2007) and Haigh's (2003) studies, service-users often felt that endings of therapeutic relationships were not addressed adequately and that the removal of services or possibility for discharge discouraged improvement. In both of these studies, service-users felt there was often a lack of continuity of staff in teams and that staff were

unable to fulfil promises made or were not interested in finding out the root causes of behaviours.

Castillo's (2003) study found that people wanted to be listened to, treated with respect, and understood. A theme around being given more time to talk to find deeper roots of problems emerged. Service-users highlighted a need to look at why people self-harm and consider the whole person and not just a collection of symptoms. More collaboration, better out-of-hours services, and safe houses or help-lines were suggested as necessary changes.

Root (2005) described her life of suffering with BPD and struggling to leave the mental healthcare system. She felt good care should be respectful, strength-based and normalizing. She argued that the therapeutic relationship should be collaborative rather than hierarchical so that unhelpful dependency could then be minimised.

### **Evidence Base for Clinician Views**

There is limited qualitative research specifically exploring clinicians' views. However, literature suggests that clinicians such as McGowan (2008) have found through clinical experience that despite poor treatment outcomes overly coercive responses such as hospitalisation continue to be used. He suggested that this offers little more than containment and observation for people whilst Krawitz and Batchler (2006) theorised that this form of defensive practice is counter-productive for reducing self-harm. To prevent non-therapeutic interactions between hospital and service-users, Nehls (1993) commented that hospital admissions should be brief and based upon a collaborative treatment contract between the service and service-user.

Clinicians have identified more helpful service relationships. In particular, researchers such as Bateman and Fonagy (2008) emphasized the importance of forming a

secure attachment relationship that is consistent, boundaried, trusting, and collaborative. Understanding attachment difficulties is suggested by Fonagy (2001) as vital for teams to understand, particularly as Holmes (1993) empirically identified that teams need to be able to reflect on strong feelings elicited by people with BPD. As Sable (2007) theorised, consistency and reliability are important for safe exploration of difficulties whilst Marrone (1998) found clinically that the development of trust was crucial. Farina and Liotti (2005) theorised that it is beneficial to have more than one therapist working with an individual with BPD. The individual can form additional attachments and as Bowlby (1982) suggested, having a hierarchy of attachment figures might be helpful since they can seek security from subsidiary figures if the primary caregiver is absent.

Krawitz (2004) found empirically that having collaborative treatment plans is helpful in reducing the hierarchical gap that exists between service-users and clinicians. As McGowan (2008) theorised, this not only respects the individual but also gives them responsibility for their own recovery. Furthermore, Warne and McAndrew (2007) suggested this may foster a more secure relationship since the risks of mirroring past experiences of abuse where the individual was expected to be “obedient, compliant, passive and grateful” (p.159) are lessened.

In relation to boundary setting, Fallon (2001) theorised that this should be transparent and include terms of responsibilities thereby reducing inconsistencies. Theoretically, Nehls (2000) suggested that case managers need to retain power and control whilst not being too rigid and authoritarian, enabling service-users to feel more secure in the relationship. She commented that the limits of therapeutic boundaries need to be understood by the client if trust is to develop. If not, she argued that these boundaries might be viewed as a barrier to the development of collaborative relationships. Furthermore, Rosenkrantz and Morrison

(1992) theorised that practitioners should aim to be flexible, accepting and boundaried to help foster a secure attachment and promote recovery.

Having a consistent approach is suggested as helpful in forming secure attachment relationships with people who have BPD. As Bateman and Tyrer (2004) found empirically, having a consistent and shared team approach reduces team splitting and conflicts and wherever possible changes in professionals should be avoided. This helps the individual feels safer within services since inconsistent responses are minimised. Continuity of care has also been found to be important for people with BPD. In particular, Goodwin (2003) found empirical evidence to suggest that regular and dependable key workers help foster a secure relationship.

Finally, Bateman and Tyrer (2004) have commented that training and supervision are vital when working with this client group. In particular, group supervision is considered helpful for teams to make sense of strong feelings raised. As Warne and McAndrew (2007) found empirically, mental healthcare services need “to help clinicians reflect and think about their emotions rather than denying and fleeing from them and their patients” (p.159).

Although these studies help provide some understanding of helpful services, very few have employed rigorous qualitative techniques to analyse the data, thus making it difficult to draw any firm conclusions. The evidence based on clinicians’ views is particularly sparse and mainly based on assumptions about helpful relationships.

### **Summary and rationale for research**

Although people with BPD continue to be stigmatised by services, recent NHS policies and empirical research is providing increasing evidence that people with this diagnosis are treatable. There is accumulating empirical evidence that demonstrates

treatment outcomes of more specialist therapeutic models are helpful (e.g. NICE, 2009). However, most research concentrates on outcomes rather than the psychological processes involved in recovery. For example, validation and acceptance are suggested as helpful by Linehan (1993) whilst attachment, mirroring, mentalization and consistency are regarded as important by Bateman and Fonagy (2008). According to the TC model, giving responsibility to people with BPD and the role of attachment within a micro-society are regarded as helpful (Campling, 2001) but these concepts are generally guided by clinical assumptions rather than research evidence.

As this review found, there is limited empirical evidence concerning what service-users and clinicians view as helpful. The available evidence suggests that having reliable, continuous, and consistent relationships are helpful alongside carefully managed endings (e.g. Bateman & Tyrer, 2004, Crawford et al. 2007, Haigh, 2002). It also suggests that a collaborative service whereby dependency is minimised is helpful (e.g. Bateman & Fonagy, 2008; NICE, 2009).

Many theorists have suggested that attachment theory might have a particularly useful role in helpful services. Considering insecure attachments are a central feature of people diagnosed with BPD this might be an important element for services to consider too. For example, it is often suggested that people with BPD are overly-dependent whilst fearing being discharged as it re-awakens feelings of abandonment. Researchers also commented that forming a secure attachment that is trusting, safe, reliable and consistent might be important for recovery (e.g. Bateman & Fonagy, 2008; Campling, 2001; Goodwin, 2003).

This review found that certain ways in which services relate to people with BPD are perceived as unhelpful. However, clinicians such as McGowan (2008) identified that despite these poor treatment outcomes (e.g. hospitalisation) they still continue to be used. This form

of defensive practice may be particularly harmful for people with BPD since they have been found to develop overly-dependent relationships with services. As Linehan (1993) suggested, coercive responses might reinforce dangerous behaviours and over-dependence on services which in turn may prevent service-users from learning to take responsibility for their behaviours.

As this literature review demonstrates, the current evidence-base on how services are helpful for people diagnosed with BPD is limited. The existing literature is mainly based on clinicians' assumptions and descriptions about what is helpful with limited empirical evidence to back such claims. In particular, very little systematic investigation of what service users and clinicians view as helpful ways of relating to services has been published. For example, are psychological processes that have been evidenced as helpful within the newer psychological models actually helpful? Also, what do service users think? Is this different to what clinicians view as helpful and do individuals go through specific psychological processes when recovering?

One way of researching this is to ask what service-users and clinicians view as helpful and unhelpful service relationships. The National Performance Framework (DoH, 1998), suggested that gaining the experiences of NHS service-users is considered important in shaping services. A qualitative method such as grounded theory (Corbin & Strauss, 2008) could provide a preliminary theoretical model for understanding how NHS mental health services are helpful for people diagnosed with BPD and in particular how they relate helpfully to this client group. This study could also have wider implications for services. By increasing the knowledge of this area with supported empirical evidence, the NHS may be able to make more informed choices about how to help people with BPD. This might include training clinicians so there is more awareness of relational difficulties within staff teams.



However an even broader implication might be the positive financial implications of providing more effectively managed services by delivering more tailored interventions for individuals with BPD.

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## **INDEPENDENT RESEACH PROJECT**

### **Section B**

**Borderline personality disorder and helpful service relationships:**

**A grounded theory study**

Intended for publication in the Journal of Personality Disorders

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**Word count:**

**7999 (plus 199 additional words)**

**A thesis submitted in partial fulfilment of the requirements of**

**Canterbury Christ Church University for the degree of**

**Doctorate of Clinical Psychology**

**JULY 2010**

**SALOMONS**

**CANTERBURY CHRIST CHURCH UNIVERSITY**

### **Abstract**

Most research evidence relating to borderline personality disorder (BPD) focuses on how specialist psychological models are helpful rather than how mental healthcare services relate helpfully to people with this diagnosis. The following study explored this further using grounded theory methodology. Semi-structured interviews were conducted with eight mental healthcare clinicians and eight service-user participants diagnosed with borderline personality disorder. The results suggested that the most helpful services are those that can form a secure, safe and consistent attachment to individuals with BPD. These services should be accepting and validating where responsibility is shared. Least helpful are those with disorganised attachment styles where themes around dependency, invalidation, and rejection are suggested. Further research would be beneficial to ascertain if these findings are supported by other specialist mental healthcare teams with a more diverse population.

### **Borderline Personality Disorder**

Borderline personality disorder (BPD) is “a pervasive pattern of instability in interpersonal relationships, self-image, affects, and marked impulsivity” (American Psychiatric Association; APA, 1994, p.629). These difficulties are considered inflexible and have historically been regarded as problematic to treat within mental healthcare settings.

People with BPD tend to frantically avoid abandonment whilst becoming involved in unstable and intense relationships. They typically suffer from identity disturbances, emotional instability, self-harm and suicidal ideation (APA, 2000). Insecure attachment difficulties are also characteristic of this client group. As Bateman and Fonagy (2008) commented from clinical experience, these individuals tend to oscillate between care-seeking and angry withdrawal.

### **Treatability of BPD**

Lewis and Appleby (1988) suggested that this diagnosis has traditionally been given to “the patients” psychiatrists dislike” (p.44). As Allen (2004) theorised, this label holds a pessimistic, pathologising and stigmatising prognosis whilst Haigh (2006) has found through clinical experience that many clinicians believe little can be achieved in helping people with BPD. Research evidence also suggests these individuals are viewed as less likely to change and less deserving of care than people with other mental health problems (Dawson, 1996; Huband & Tantam, 1999).

Individuals with BPD are generally the most help-seeking, attract the most attention, evoke high levels of anxiety in clinicians, and often present themselves to services when they are in a crisis (Department of Health; DoH, 2003). However, clinicians are becoming better

informed about treatment options and within the UK, recent National Health Service (NHS) policies have contributed to more positive reframing of BPD.

### **Recent NHS Policies for Managing BPD**

Recent NHS policies by the DoH (2003), National Institute for Mental Health in England (NIMHE, 2003), and the National Institute of Clinical Excellence guidelines (NICE, 2009) identified that people with BPD are often stigmatised, over-medicated, and treated at the margins of healthcare services. It was highlighted by the DoH (2003) that this creates „revolving-door“ service-users, with multiple admissions, inadequate care planning and infrequent follow-up procedures.

These documents emphasized person-centred, collaborative, optimistic and trusting relationships. The need for specialist personality disorder services, crisis resolution teams, and planned short admissions were identified as helpful (DoH, 2003; NICE, 2009) whilst a framework supporting the development of necessary clinical skills and training was provided by NIMHE (2003). Psychological treatment was considered helpful when treatments were well-structured, explicit, focussed, relatively longer-term, and theoretically coherent with well-managed endings (Bateman and Tyrer, 2004; NICE, 2009).

These policies provide a helpful framework for treating people with BPD but a consideration of the empirical research comparing unhelpful and helpful service relationships is required.

### **Unhelpful Services**

Sampson (2006) suggested that from clinical experience most mental healthcare services medicalise symptoms. He argued that the emphasis on diagnosis, symptom reduction, and drug treatment was unhelpful. Hodges (2003) found empirically that this

approach provides limited understanding of the aetiology and relational difficulties whilst also pathologising and stigmatising people. Haigh (2002) further reported that based on empirical evidence, service-users identified that they would prefer less emphasis on symptoms and more on acceptance, attachment and validation.

Another service shortfall is that they often promote dependency when inadequate support is provided. Koekkoek, Van Meijel, Schene, and Hutschemaeker (2009) found empirically that people with BPD often do not receive optimal therapeutic help and may resort to self-harming to access further support. Subsequently, more care is provided but once symptoms subside, the threat of discharge may trigger unmanageable feelings of rejection and abandonment. A suicide attempt may occur as an attempt to re-establish relationships but also reinforces dependency when the service provides additional care. Paris (2008) theorised that this overly-dependent, insecure attachment relationship is particularly unhelpful.

Theoretically, Campling (1999) has suggested that it is particularly unhelpful when professionals' fear of accountability leads to them taking increased responsibility for service-users behaviour. This may lead to restrictive and coercive interventions (e.g. hospitalisation) that McGowan (2008) commented may be detrimental to recovery. He theorised that by fulfilling the individual's need for care, hospitalisation prevents people from making a choice to recover. Bateman and Tyrer (2004) have found through clinical experience that this increases the dependency professionals aim to avoid whilst Linehan (1993) theorised that this inadvertently reinforces dangerous behaviours. Indeed, Paris (2004) suggested the hospital provides "little more than a suicide watch" (p.224).

When an insecure attachment relationship between mental healthcare services and people with BPD develops, Holmes (2003) theorised that these individuals are less likely to



recover. For example, Haigh (2002) argued theoretically that the inconsistency and dependability of key staff, particularly on inpatient wards, means that those deemed more powerful (e.g. consultant psychiatrists) are experienced as inconsistent parental figures when they are unavailable. Gunderson (1996) also theorised that changes in professionals and inconsistencies in these relationships may re-awaken feelings of loss and abandonment.

Another difficulty often found in mental healthcare settings is the issue of power and conflict. Brown (1992) theorised that the authoritarian, hierarchical context of mental healthcare treatment replicates abusive situations from individuals' pasts. Nehls (1998) purported that professional systems are often conflicting, fragmented, and overstretched. This potentially replicates the fragmentation, inconsistency, untrustworthiness and intrusion of earlier childhood experiences that foster insecure attachments.

As the literature suggests, there are a number of unhelpful service relationships with people with BPD. However, what does the current literature suggest as helpful ways of relating?

### **Helpful Psychological Models of Relating**

Research evidence (e.g. NICE, 2009) suggested that psychological models specifically designed for BPD are therapeutically helpful. This includes dialectical behaviour therapy (DBT), mentalization-based therapy (MBT) and therapeutic communities (TC).

#### **Dialectical behaviour therapy model.**

DBT was developed by Linehan (1993) and directly targets suicidal ideation, treatment-interfering behaviours, and other dangerous behaviours through regulating emotions. Within this model, Linehan (1993) has empirically found that validation and

acceptance are vital for change to occur. As Linehan and Dimeff (2001) suggested, the therapist uses dialectical strategies aimed at accepting and validating the client's feelings whilst suggesting alternative coping strategies. According to Grossman and Grossman (2005) this promotes a secure attachment within a therapeutic relationship that fosters recovery.

Within this model, Swenson, Witterholt, and Bohus (2007) found empirically that a secure attachment is best achieved within a shared case management framework thereby maintaining consistency and reliability. As Sable (2007) suggested this minimises inconsistent reinforcement of maladaptive behaviours that might perpetuate insecure attachments. By adopting this stance, Allen (2004) theorised that the unhelpful dependency and invalidation often found in mental healthcare settings is discouraged.

### **Mentalization-based therapy model.**

MBT was specifically designed for individuals with BPD (Bateman & Fonagy, 2004) and is rooted in attachment theory. Central to this model is that people with BPD fail to develop a mentalization capacity within attachment relationships. As Bateman and Fonagy (2008) theorised, people with BPD struggle to recognise, tolerate, and respond to mental states, often misinterpreting thoughts, feelings and behaviours. Through a safe and secure attachment Fonagy (2001) empirically found the capacity to mentalize can be developed. Bateman and Fonagy (2008) have also theorised that when the therapist mirrors the individual's emotions a consistent and secure base for exploration is provided.

Bateman and Fonagy (2008) suggested that MBT should foster secure attachments by having a consistent, constant and coherent approach since individuals with BPD "detect and exploit inconsistency" due to their disorganised attachment systems (p.187). MBT's flexible

stance and level of intensity is also helpful since service-users do not feel abandoned between sessions.

### **Therapeutic communities model.**

The TC approach promotes well-being through social relationships, daily structure and group therapies. As Norton and Dolan (1995) have found empirically, this model is helpful in providing a structured, predictable, and boundaried environment where supportive relationships are formed. Collective and collaborative decision-making and voting procedures are often used whilst a flattened hierarchy and equality are promoted. As Campling (2001) theorised, this facilitates the development of secure attachments that can withstand high levels of aggression and risk.

According to this model, the paternalistic relationship style of CMHTs and inpatient services is unhelpful. TCs give more responsibility to the individual and as Hinshelwood (1999) theorised, this frees clinicians to take therapeutic risks that CMHTs often avoid.

Qualitative studies by Hafner and Holme (1996) and Morant and King's (2003) suggested service-users found group-work, community living, and being given responsibility particularly helpful with this model. Difficulties returning to CMHTs after being in a TC were suggested. This was because CMHTs were viewed as too passive and encouraged over-dependency.

These models provide psychological principles for working with BPD. However, do clinicians and service-users value these therapeutic principles? The evidence from service-users and clinicians is presented.

**Evidence from Service-Users**

There is limited research evidence concerning what service-users value. However, Haigh (2002) found empirically that service-users appreciate therapeutic choice and forming trusting relationships. Service-users felt clear communication, continuity of care, and having a shared understanding were helpful whilst the label „personality disorder“ was found to be problematic and stigmatising.

Crawford et al.'s (2007) qualitative study found common themes around feeling rejected and badly treated by services. Service-users wanted welcoming, flexible and accessible services whereby less rigid rules were implemented. Some way of retaining a link with services post-treatment was deemed helpful. Endings of therapeutic relationships were also often felt to be inadequately addressed. In both of these studies, service-users felt that staff often did not fulfil promises and seemed uninterested in aetiology. Specialist services had a strong sense of belonging through shared experiences and were viewed as more optimistic.

Castillo's (2003) study found that service-users wanted to be listened to, treated with respect, and understood. Service-users valued clinicians who considered the whole person rather than a collection of symptoms.

**Evidence from Clinicians**

There is limited qualitative research specifically exploring clinicians' views. However, McGowan (2008) has found through clinical experience that despite poor treatment outcomes, overly coercive responses (e.g. hospitalisation) continue to be used. Paris (2008) argued that this rarely provides a form of safety and Krawitz and Batchler (2006) theorised

that this form of defensive practice was counter-productive for reducing self-harm, reinforcing dangerous behaviours and over-dependency.

Clinicians have identified helpful service models whereby the formation of a secure attachment is generally recognised. As empirically suggested by Fonagy (2001) and Holmes (2003) this includes clinicians valuing the attachment relationships whilst recognising attachment difficulties. For example, Bateman and Fonagy (2003) theorised that overly coercive relationships should be avoided by clinicians since they create over-dependency and insecure attachments to services.

Based on clinical experience, Krawitz (2004) suggested that treatment plans should be collaborative between service-users and clinicians. As McGowan (2008) commented, this respects the individual whilst returning responsibility to the service-user for their own recovery. Bateman and Tyrer (2004) also empirically found that having a consistent and shared approach is helpful; reducing inconsistent responses from services that facilitate insecure attachment relationships. Having transparent boundaries also provides consistency. As Bateman and Fonagy (2008) have theorised, this creates a more containing therapeutic attachment. However, when services break boundaries they found that individuals with BPD struggle to hold in mind different representations and affects, so they feel less secure within these settings.

Finally, Bateman and Tyrer (2004) have found from clinical experience that training and supervision are vital when working with this client group. Warne and McAndrew (2007) theorised that teams need to be able to reflect and think about their emotions to support stronger attachment relationships between services and individuals with BPD.

## **Research Rationale**

The current evidence-base on how services are helpful for people diagnosed with BPD is limited. Most of the research literature is based on clinicians' assumptions about what is helpful with limited empirical evidence to support such claims. In particular, there has been very little systematic investigation of what service users diagnosed with BPD and clinicians working in the field view as helpful and few wider inferences and clinical implications have been suggested. For example, there is little or no research regarding how services might relate more effectively to service-users with BPD. Consequently it seems logical to explore the dyadic relationship between services and their users. To do this, the views of service-users with a diagnosis of BPD need soliciting in addition to exploring aspects of service provision.

Empirical evidence from specialist psychological service models is suggestive of beneficial outcomes. However, are these psychological principles valued by service-users with BPD and clinicians and which psychological processes are helpful? This might include DBTs principles of validation or MBTs principles of mirroring and attachment. Alternatively, the TC principles of responsibility and reduced dependency might be helpful. NHS services need empirical research to support theorists' assumptions so that service designs can be evidence-based.

## **Research Aims**

This study aimed at identifying what mental healthcare clinicians and service-users diagnosed with BPD perceived as helpful service relationships for people with this diagnosis. It was anticipated that a preliminary psychological model demonstrating how services relate to people with BPD would be conceptualised through an investigation of people's

experiences of either providing care (clinicians) or receiving care (those diagnosed with BPD). The research questions were:

1. What do service-users diagnosed with BPD and mental healthcare clinicians perceive as helpful and unhelpful ways of relating to mental healthcare services?
2. Are there differences in what service-users diagnosed with BPD and clinicians working in this field believe are helpful?

## **Method**

### **Design Overview**

A qualitative design using semi-structured interviews was employed since the research evidence was limited and the research questions were explorative. Furthermore, investigating how mental healthcare services were helpful for people diagnosed with BPD was likely to involve diverse processes that qualitative methodologies might capture (Smith, 2003).

Grounded theory (GT; Strauss & Corbin, 1998) was identified as a particularly useful methodology for this research for three reasons:

1. It provides a framework for assessing and understanding individual meanings (Strauss & Corbin, 2008).
2. It ensures rigour and control of subjectivity when analysing data (Mayes & Pope, 1995).
3. It provides a systematic and emergent understanding of the psychological processes involved and a preliminary theoretical model of helpful services (Henwood & Pidgeon, 2003).

**Participants**

Two samples of participants were included in this study; service-users diagnosed with BPD and mental healthcare clinicians who had worked with individuals given this diagnosis. The rationale for using two groups was that the views of service-users and clinicians might vary in what they perceive as helpful service relationships. This method also helped triangulate views, increasing the reliability of the findings.

All participants were recruited from a wide geographical area covering two NHS mental health Trusts in the South East of England (appendix 1 & 2).

**Selection criteria for service-users.**

- Formally diagnosed with BPD and to be aware of this diagnosis.
- Adults aged between 18 and 65 years and were under the care of the local NHS Trust at the time of conducting the interview.
- To be completing treatment within 6 months of interviewing. These participants were felt to be more able to consider how services had possibly helped them.

**Selection criteria for clinicians.**

- Clinicians with experience of treating BPD.
- Formally qualified in their relevant disciplinary background.
- Working within the local NHS Trust at the time of interviewing.

**Sampling technique.**

This study employed purposive systematic, theoretical sampling (Strauss & Corbin, 2008) whereby potential participants were identified who possessed characteristics relevant to



the purposes of the investigation, rather than random or representative sampling. The emerging theory determined the sampling strategy used, ensuring a diverse range of participants were included in order to increase the generalisability of results. The process of sampling continued until saturation occurred<sup>3</sup>. Sixteen individuals participated in the study (eight clinicians and eight service-users). By interview 14, the same themes emerged and by interview 16, theoretical saturation had been achieved since no new categories were developed.

## **Procedure**

Ethical approval (appendix 3) was obtained from the NHS National Research Ethics Committee and the BPS code of ethics and conduct (2006) was adhered to throughout the study. The sensitive nature of the topic was highlighted to participants and the limits of confidentiality were made explicit.

Potential NHS services were contacted directly and the lead researcher attended various team meetings to discuss the research project. Invitation letters (appendix 4) and information packs (appendix 5) were given to interested clinicians and asked to contact the researcher if they would like to participate. Invitation letters and information packs (appendices 6 & 7) for service-users were provided so that care-coordinators could inform potential service-users about the study and help them make informed decisions regarding participation before any further contact was made by the researcher.

At interview, written consent was obtained (appendix 8). Interviews lasted 30-90 minutes and took place either at the participant's workplace or where the participant was seen for treatment.

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<sup>3</sup> Whereby no new properties or relationships emerge from the data (Strauss & Corbin, 2008)

Clinician and service-user interview schedules were developed by the researcher (appendices 9 and 10). Both interview schedules were initially piloted on two fellow colleagues, helping ensure the questions flowed well and were appropriate to the research question. The questions were also compiled based on themes identified in the research literature and were later modified as the research progressed, thereby allowing further exploration of the emerging categories.

Following each interview, participants were debriefed and given the opportunity to discuss any concerns raised. All interviews were digitally recorded and transcribed verbatim with any identifying information removed.

### **Data Analysis**

Interview transcripts were analysed using „analytic tools“ within GT procedures (Charmaz, 2006; Strauss & Corbin, 2008). The coding progressed through the following stages although not in a strictly linear way:

1. The first 4 interviews were open-coded using line-by-line coding and placed into descriptive codes.
2. Focused coding helped generate codes to describe larger sections of data using constant comparisons (Willig, 2001).
3. Axial coding helped explore the relationships between categories and sub-categories, developing main categories and sub-categories.
4. Selective coding was used to generate a main overall theme from the data to link the categories generated.
5. Memos recorded reflections on the data and provided a data trail of category development (Strauss & Corbin, 2008).
6. The model was checked against raw transcripts to ensure accuracy of sorting.

## Methodological Rigour

Numerous techniques aimed at enhancing the integrity of the research were conducted including having regular supervision, intensive engagement with the analysis and monitoring of this. Additionally, the following techniques were undertaken:

1. A research diary (Lincoln & Guba, 1985) recorded personal responses and potential biases to the data.
2. Respondent validation (Henwood & Pidgeon, 2003) via a meeting with three service-user participants who judged the validity and accuracy of the main categories. Service-users generally agreed that the findings were valid and representative of their views.

## Results

### Participant Characteristics<sup>4</sup>

A summary of participant information gathered at interviews is provided in tables 1 and 2.

**Table 1: Clinician characteristics**

Participant	Profession	Gender	Years clinical experience	Service context
C1	Psychiatrist	Male	30-40	CMHT
C2	Clinical psychologist	Female	> 10	CMHT
C3	Psychiatric nurse	Female	30-40	CMHT
C4	Psychotherapist	Male	>10	CMHT
C5	Group analyst	Male	30-40	TC
C6	Psychiatrist	Female	40-50	TC
C7	Clinical psychologist	Male	10-20	CMHT
C8	Psychiatric nurse	Male	30-40	Inpatient

<sup>4</sup> All identifying information has been removed throughout this report.

As table 1 illustrates, eight clinician participants were recruited from various clinical backgrounds. All participants had at least five years clinical experience. Three females and five males were interviewed and all were from White British backgrounds except one who was of Asian origin.

**Table 2: Service-user characteristics**

<b>Participant</b>	<b>Gender</b>	<b>Years in mental health services</b>	<b>Service context</b>
SU1	Female	>20	CMHT
SU2	Female	>20	TC
SU3	Male	5-10	TC
SU4	Female	<5	TC
SU5	Male	10-20	TC
SU6	Female	<5	TC
SU7	Female	>20	Inpatient
SU8	Female	>20	Inpatient

As shown in table 2, eight service-user participants were recruited and all had a formal diagnosis of BPD. Six female and two male participants were recruited and all were of White British origins. They were recruited from a variety of mental healthcare settings. A broad length of mental healthcare service involvement was identified.

From the interviews, two primary categories (healthy and unhealthy relationships), eight main categories, and 23 subcategories were developed and most themes were shared by both service-user and clinician participants (see appendix 9 for results).

Each of these themes will be described using quotation examples from the data and a psychological model based on the findings will be presented.

## **A. Healthy Relationships with Services**

### **Category 1: Secure Attachment**

#### **Clinicians as safe parental figures.**

A strong theme emerged about helpful services providing a safe attachment for individuals with BPD. All participants felt it was important for a secure, nurturing attachment to develop for safe exploration of personal difficulties. Service-user participants described helpful clinicians as being like ideal parental figures.

*“She was a mother figure...and I’ve always longed for that care.” (SU1)*

*“He was a very good father figure role... I think I got very attached to him as a positive figure.” (SU2)*

*“I have entered her inner world as a good object, consistent, caring object, which she can use, like one might, the synthesis of a mother.” (C6)*

Some clinicians suggested the attachment relationships might further develop if provided with continuity. In particular, some participants felt it was helpful for services to accept people back for treatment post-discharge, providing continuity within a trusting attachment relationship.

*“The service becomes a secure base in which people can go off and explore their lives but if there is a crisis they can come back to somewhere that they feel is safe to someone that can trust and where they feel a constant and stable response.” (C7)*

### **Establishing trusting relationships.**

The importance of services developing trusting attachment relationships was suggested by most participants, particularly service-users. There was agreement that longer treatment timeframes with some continuity were helpful in forming a secure attachment.

*“Given the chance to open up and given the time that you need to open up...It’s the trust that’s important.” (SU3)*

*“Having somebody who the client knows well and trusts to engage with them during a crisis is incredibly helpful.” (C7)*

However, some participants found it particularly unhelpful if services made false promises or failed to explain their limits of confidentiality resulting in the attachment relationship really suffering.

*“It was because she raised my expectations. She said I’ll meet you at a certain time so I went to the office and she wasn’t there...so the disappointment was building up.” (SU6)*

*“At least you are giving the person some hope that something will be done about it and a trust will be built up as long as you go and do it.” (C8)*

### **Consistency in relationships.**

Participants felt services needed a consistent approach enabling healthy therapeutic attachments to develop. This included consistent responses from clinicians, teams, and services whilst continuity in clinicians seen was important.

*“It makes a huge difference when you see someone who is really good and is consistent over time. You know what you can expect from that person.” (SU5)*

*“Consistency, availability, consistent philosophy, background philosophy that the team holds in common is helpful.” (C6)*

There was agreement that inconsistent service responses were unhelpful resulting in feelings of confusion, rejection and insecurity.

*“You do get a lot of different opinions off a lot of people from the same profession. It’s very confusing.” (SU3)*

*“I’m really opposed to this quickly moving from team to team and person to person approach. Passing people around isn’t actually going to build up a relationship.” (C6)*

### **Boundaried and challenging clinicians.**

Most participants felt that having clear and consistently boundaried clinicians was helpful in providing safe containment. Furthermore, participants suggested that sometimes the services themselves provided the boundaries for people who might otherwise be unable to cope.

*“They have strong boundaries and they explain those boundaries so I feel safe enough here.” (SU3)*

*“It’s the unit that provides a boundary...and if you take away the unit then they fall to pieces.” (C7)*

Most service-user participants felt it was important to feel well-held and challenged by clinicians. Knowing they were strong enough to cope with their problems provided a sense of security whilst clinicians who were “*too soft*” (SU1) were felt to be unhelpful.

*“I was angry with him because I knew he was right...it helped me to see where I was going wrong and it felt OK as he could cope with me being angry with him.”* (SU2)

## **Category 2: Acceptance and Validation**

### **Sense of belonging.**

Having a strong sense of belonging, inclusion, and acceptance was recognised as helpful by participants. This was particularly important for more socially isolated individuals and for those who had limited support networks.

*“It is very useful for people to feel a part of something when often they are alienated from friends, family and they often don’t have any substantial relationships outside.”* (C6)

*“I’ve made a lot of friends here as we’ve got similar problems.”* (SU2)

Group identity, particularly where self-harm was involved, was identified as helpful for individuals who felt ashamed or invalidated by this behaviour. Relating to others with similar difficulties was viewed as supportive and helped individuals form attachments to other service-users.

*“A lot of us are self-harmers so we can understand a lot of where we are coming from and can respect each other.”*(SU2)



### **Being listened to and understood.**

Most participants felt it was important for service-users to be listened to, understood, and respected. This was identified as validating and possibly fostered more secure relationships within these settings.

*“Actually understanding you on another level which is personal perhaps or wanting to know about your past.” (SU5)*

### **Belief and respect in the individual.**

Service-user participants described helpful services as validating their feelings and showing respect. This helped individuals feel accepted and more empowered towards recovery.

*“They genuinely seemed to find the best in me. They complimented me on how I was doing.” (SU8)*

*“I think he really believed in me and he actually said I was a pleasure to work with.” (SU1)*

## **Category 3: Responsibility and risk (clinicians only)**

### **Shared inter/intra service approach.**

It was commonly agreed that having a shared model of understanding between services, clinicians and teams was important. Where teams did not share a model of understanding (e.g. CMHTs) it was found to be unhelpful.

“Having a named model that everybody is on board with. Everybody does the same model and uses supervision groups; the team working together all within the same model.”(C2)

In particular, this provided a more consistent and shared approach to risk management that was felt to be supportive for clinicians.

*“People are on board with the model and way of thinking so you can share the risk and share the way of thinking about people.” (C2)*

It was also suggested that intermittent responses from services reinforced self-harm in service-users and that having a shared understanding across agencies would reduce inconsistency.

“Certain responses reinforce dysfunctional behaviours and if those responses are *given intermittently then that’s a powerful reinforcer of behaviour.*” (C1)

### **Clinicians taking positive risks.**

Participants felt it was useful to avoid using overly coercive methods when managing risks, including under-reacting to situations, trying to keep people out of hospital and discharging people from inpatient settings as early as possible.

*“Don’t inadvertently reinforce damaging or dysfunctional behaviours by only giving attention to someone when they cut themselves. It isn’t necessarily going to reduce the frequency of cutting.” (C1)*

*“To discharge the patient as soon as the crisis has settled, to not keep them in hospital observing them and encouraging them to take positive risks.” (C6)*

**Giving responsibility to service-users.**

Participants felt services should give more responsibility to service-users for managing their behaviours as this would empower individuals and help them learn to cope whilst reducing their overall dependency.

*“She was trying to make me anxious and for me to take responsibility for her behaviour but I wasn’t going to do that. She needed to become more responsible for her behaviour.”(C1)*

*“I wish that people on the wards were being required to do some thinking and take some responsibility for their behaviours rather than just stepping into the obis.” (C5)*

**B. Unhealthy relationships with services****Category 4: Invalidation and Rejection****Difficulties being discharged.**

Feelings of rejection and abandonment were identified as problematic by participants. For service-users there was a fear of being discharged and not being able to cope without the support from services.

*“I do worry that if I crash, if things get on top and I don’t sort of continue what we’ve learnt here.” (SU4)*

Most participants felt that being discharged led to individuals feeling rejected especially when treatment endings were not handled appropriately by services as was commonly found on inpatient wards.

*“You can’t just leave me now. I need you to help me make sense of all this.” (SU1)*

*“Their experience of the discharge from the ward is felt as a big rejection. The time of discharge seems to be quite arbitrarily decided but actually the whole system has had enough of working with them.” (C2)*

### **Exclusion and abandonment in services.**

A strong theme around people being excluded and abandoned by services, particularly during crises, was identified.

*“I wanted therapy and he refused to see me.” (SU1)*

*“I felt so alone because no one wanted to help me.” (SU7)*

*“When [ the doctor left the service] I felt as if I’d just been dumped, like what my family have done, so called friends have done, so I thought the system itself was letting me down.” (SU8)*

Clinicians also recognised that services often excluded and invalidated people based on their diagnosis or because the team is struggling to work with this person.

*“What you get is a lot of clinicians pushing people away and reinforcing what this person is struggling with in the first place. It’s feelings of being unheard, rejected, etc.” (C5)*

### **Sense of being judged and misunderstood.**

Most participants felt people with BPD were pathologised, judged, or blamed with some services being dispassionate and invalidating of people’s difficulties.

*“One of the things that was said to me very early on...is you’re bound to criticise or question because that’s part of your personality disorder.”(SU6)*

“The phrase PD is often used as an insult for people.” (C3)

### **Feeling ignored.**

Service-user participants found this particularly invalidating. They felt unhelpful services did not listen or try to understand them especially when services were busy (e.g. on inpatient wards).

*“I couldn’t put it into words at that time how I was feeling but at the same time nobody really wanted to find out.”(SU1)*

*“They think oh let her shuffle up and down the [ward] corridor because as long as she is locked in, why should we care?” (SU8)*

## **Category 5: Dependency**

### **Wanting to be cared for by services.**

Feelings of dependency and wanting to be cared for by services were identified as problematic mainly by clinician participants. The „revolving door“ phenomenon was described by clinicians as particularly unhealthy.

*“They take an overdose due to some crisis...and present to A&E and get admitted to hospital, quite like it in hospital but at the same time resent it, go out, do the whole thing again.”(C5)*

Some service-users also identified their own responses as being somewhat dependent and wanting to be cared for, continuing the cycle of dependency.

*“I cut my neck open and [the psychiatrist] came down to A&E and sat with me and that was the happiest I’d ever been because I had that care that I wanted.” (SU2)*

*“It was like a vicious circle ...I was just in and out of hospital but at least in hospital I felt cared for.” (SU8)*

### **Isolation and dependency (service-users only).**

For service-user participants who felt socially isolated and lacked social support there was a stronger theme around dependency on services. When these individuals could not access appropriate help from others, services became their main support system, particularly during crises. However, participants identified that service responses were often inconsistent and this possibly contributed to feeling dependent on services.

*“I’d even phone the ward some nights just to talk to somebody and sometimes they would talk to me for a while but not often and that’s because I had no one else to talk to.” (SU1)*

### **Blaming services for dependency (clinicians only).**

Clinicians seemed to agree that services often related unhealthily, contributing to over-dependency on services. Themes around services providing inconsistent responses, being overly-responsible, and not teaching coping skills were discussed.

*“We need to behave more healthily to help people with Borderline behave more healthily. Our whole system is set up to allow that type of dysfunctional interaction with services.” (C1)*

*“The service encourages people to be dependant. Instead of teaching people how to solve their problems someone will solve their problems for them.” (C3)*

There was recognition that service dependency was also a way of requesting help and services needed to try to understand the meaning behind these behaviours.

*“Somebody wouldn’t have to repeat something again and again if they weren’t trying to tell you something. There’s no point in acting out in a certain way again and again if the other person picks up whatever you’re distressed with.” (C7)*

## **Category 6: Symptom Management**

### **Medication and overmedication.**

Participants felt medication was unhelpful and particularly that medication only numbed individuals’ feelings rather than helping people deal with the root causes of problems.

*“All medication does is push your problems away, hides it, suppresses it and calms the emotions down instead of actually facing up and dealing with the emotions.”(C5)*

Participants’ experiences suggested that over-medicated and sedation were used unhelpfully as a form of symptom control or risk management.

*“Over the years psychiatrists have tried to manage people’s interpersonal problems by sedating them.”(C5)*

“I was just drugged up to the eye balls.” (SU1)

### **Patching up symptoms.**

Some participants felt that short-term work was unhelpful since a secure attachment was less likely to be achieved and relational issues avoided. Brief therapies were suggested as particularly unhelpful; simply managing symptoms rather than relieving people in the longer term.

“I find that CBT it may fix the problem temporarily for that moment but it *doesn't* actually deal with where the underlying issues are.”(SU5)

“*They* have to get rid of the ridiculous constraints about time. They have this fantasy about what treatment is and it does not bear any resemblance to treatment”. (C3)

## **Category 7: Disempowerment**

### **Ward environment and abuse.**

Service-user participants who had experienced inpatient settings described traumatising experiences (e.g. aggression, being disliked by staff, or re-traumatised by past experiences of rejection, abuse, or abandonment).

“It can be pretty brutal sometimes the care you get in hospital.” (SU2)

“*On the wards they have sworn at me. They think you're so bad that they can swear at you if you don't get along with them.*” (SU8)



Some clinician participants also identified the ward environment as abusive, un-empathic, and invalidating. Participants suggested these environments were unsafe and difficult to form secure attachments.

*“[Ward staff] don’t think [people with BPD] are ill in the sense that psychotic patients are ill so they keep re-experiencing the past traumas of rejection, antagonism, and so forth with people who are so called parental figures.” (C6)*

### **Unhelpful power differences (service-users only).**

Service-user participants felt that having authoritative services that were governed by strict rules were unhelpful. In particular, having a strict patient-doctor relationship felt invalidating.

*“There’s a non-empathic way about [seeing psychiatrist], it’s very clinical, I am the doctor and you are the patient.” (SU5)*

### **Disempowerment through lack of diagnosis sharing.**

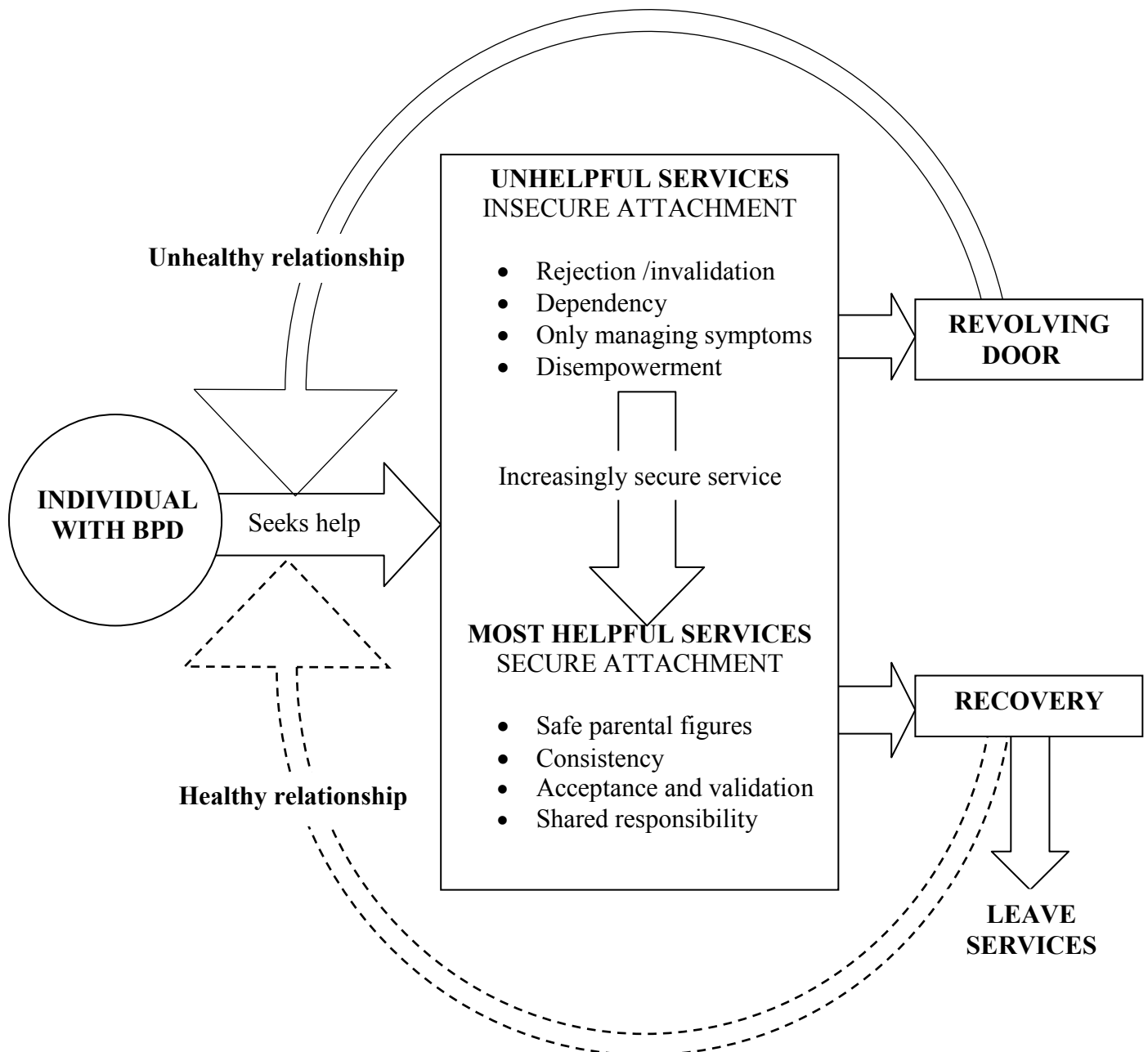
All service-user participants saw the value in being given a diagnosis compared to only a few clinician participants. For most service-users their diagnosis had only been shared with them very recently and this was empowering (e.g. researching about it and feeling normalised). However, most participants recognised the inherent diagnostic stigma associated with this.

*“I had been in the system for 20 years and been diagnosed with bipolar and clinical depression. So I was relieved to get a diagnosis, a correct diagnosis” (SU2)*

### A psychological Model of Service Relationships

Based on the themes that emerged from the research, a model was developed using attachment theory principles (see figure 1).

**Figure 1: Model of Helpful Services**



This model suggests that services vary in attachment styles from disorganised through to secure services. The „healthy“ service model for people with BPD suggests clinicians become safe, containing „parental“ figures where exploration of difficulties can occur within a boundaried relationship. This form of attachment requires a consistent and trusting approach whereby a shared model of understanding and risk management is established. Service-user responsibility, acceptance and validation are promoted with the aim of recovery. These services also accept that people may need to return to services post-treatment if crises occur; forming a more mature attachment style.

The model suggests that less helpful services result in a disorganised attachment style resulting in individuals feeling rejected, abandoned yet dependent on services. This attachment style is inconsistent and fragmented with services focussing on symptom management rather than relational difficulties. Such services may be re-traumatising for people (e.g. inpatient wards) where they feel disempowered and rejected. When this occurs, people are less likely to recover and more likely to enter into a „revolving door“ relationship where the individual has chaotic use of services, becomes pathologised by teams and feels dependent upon them.

### **Discussion**

Most of the current literature on BPD and mental healthcare service relationships is based on theoretical assumptions from clinical experience with limited empirical evidence to support these views. Although the research evidence suggests numerous specialist psychological approaches have positive treatment outcomes for BPD (e.g. NICE, 2009), little is known about what clinicians and service-users view as helpful and unhelpful psychological processes for recovery.

This study explored this further with particular emphasis placed on understanding whether psychological processes outlined in more specialist psychological approaches were helpful for recovery. These findings will be summarised followed by a consideration of clinical implications and future directions for research.

### **Key Findings and Theoretical Implications**

This study found that the most helpful mental healthcare services were those that provided a secure and „healthy“ attachment to individuals with BPD. Themes around services forming safe, boundaried, trusting and consistent relationships were identified and this supported previous research findings (e.g. Fonagy, 2001; Holmes, 2003) and it is within such secure attachments that Bateman and Fonagy (2008) theorised that individuals can learn to mentalize.

Similarly to Crawford *et al.*'s (2007) empirical findings, some participants in this study felt it was helpful for individuals with BPD to retain links with services post-discharge if they had formed secure attachments to the service or clinician. This included requesting further therapy sessions during crises as opposed to chaotic emergency visits and inpatient stays commonly cited as unhelpful (e.g. NIHME, 2003; Paris, 2008). Participants suggested this type of relationship provided more continuity since a trusting therapeutic attachment had already developed whereby the individual felt safe enough to explore difficulties. This form of help-seeking behaviour was viewed as a healthier response at times of distress since individuals could request help in a more contained way with the service being more accepting of the individual's attachment needs. Clinician participants also suggested this was less likely to reinforce unhelpful dependency and dysfunctional behaviours since these individuals could contact the service if they needed to rather than denying them help. This confirms Koekkoek *et al.*'s (2009) empirical study whereby if people receive sub-optimum care they

are more likely to self-harm to gain further care from services. These findings also supported Bateman and Fonagy's (2008) theoretical claim that consistency is an important aspect of helpful services and attachment formation within their MBT model.

As this study found, the whole service needs to respond consistently for a secure attachment to develop. Service-user participants suggested that this could be promoted by ensuring reliable information provision (e.g. diagnosis), consistent appointments with clinicians, and improved inter-service communication.

Clinician participants felt it was especially helpful to have a shared model of understanding that incorporated shared risk management. Having a shared understanding is a central concept of the MBT, DBT and TC models and research evidence suggests this reduces team fragmentation, anxieties regarding risk management, and splitting within teams (e.g. Bateman & Tyrer, 2004; Campling, 2001; Nehls, 1998). This also seems to foster secure attachments to services since the individual has some predictability in clinicians' responses.

Although consistency was recognised as helpful, most participants identified some services (e.g. inpatient wards) that were particularly inconsistent. As Haigh (2002) found empirically, if services are inconsistent then insecure attachments develop with often the most powerful clinicians being deemed as inconsistent parental figures who cannot be trusted. Thus, this study's findings support more specialist models whereby services have a shared model of understanding which promotes a consistent and boundaried approach that helps the individual feel less frightened and more secure within the relationship.

This study found that Linehan's (1993) DBT concepts of acceptance and validation were very useful. This included services needing to listen to, accept, and respect individuals

with BPD whilst also being able to challenge them. As Grossman and Grossman (2005) found, this promotes a secure therapeutic relationship since individuals feel accepted, cared for, and safe enough to encourage exploration of difficulties within a validating environment whilst unhelpful dependency and invalidation of other settings is also reduced (Allen, 2004). Such findings supported Castillo's (2003) and Crawford *et al.*'s (2007) empirical findings that service-users would like welcoming, flexible and accessible services where they are listened to, understood and respected.

The formation of social support and having a sense of belonging was found to be very helpful, especially when individuals with BPD were more socially isolated or lacked support outside of mental healthcare services. This is particularly emphasized by Campling (2001) in relation to the TC model but both MBT and DBT also use group work to help individuals with BPD. These models not only offer a relational learning experience through groups but also help service-users form supportive peer groups that might reduce dependency on services since people can form attachments to their peers and provide support that is external to the service.

As Bateman & Tyrer (2004) have found from clinical experience, individuals with BPD rarely take responsibility for their behaviour if services are willing to accept this. Clinician participants tended to agree with this claim suggesting services often did not take positive risks nor give enough responsibility to service-users. This somewhat supports Hinshelwood's (1999) claim that a particularly helpful characteristic of TCs is that they give more responsibility to individuals to manage their behaviours with mutual community responsibility being particularly useful (Campling, 2001). However, this theme was not identified by service-user participants and suggests these participants did not view this as

helpful or alternatively they possibly continued to feel some dependency on services helping them through crises.

The findings from this study support the TC model of having a flattened hierarchy whereby a sense of equality is provided. Participants suggested helpful services are those where there is more equality between clinicians and service-users compared to unhelpful services where large power differences and authoritative coercive rules are in place. As Brown (1992) theorised these types of services (e.g. inpatient wards) might reawaken past abusive situations and insecure attachments so powerlessness needs to be reduced. However, as Campling (2001) suggested theoretically, collaborative working promotes equality and is especially important in facilitating an attachment that can withstand aggression and risk. As this current study found, this includes diagnosis sharing that is so often avoided by services.

This research also highlighted that participants continued to find some service relationships unhelpful. This was particularly suggested in general mental healthcare settings (e.g. CMHTs and inpatient wards). These services were often identified as rejecting, invalidating, and un-accepting and often stigmatised people based on their diagnosis. This confirms Allen's (2004) theoretical claim that this diagnosis continues to be stigmatising. The ward environment was considered particularly invalidating and rejecting and supported Dawson's (1996) comment that there is a limited understanding of BPD in these environments.

The focus on medicalising symptoms often described in CMHT settings (Sampson, 2006) was also found to be unhelpful for this client group since they did not „treat the root cause of the problem“. As Haigh (2002) found empirically, individuals with BPD want less

emphasis on symptoms and more on acceptance and attachment as found in specialist psychological service models.

In essence, this study suggests that services need to provide a containing attachment that encompasses the psychological principles of attachment (e.g. safety, consistency, boundary-setting, and trust) that is commonly suggested in specialist models, particularly with relation to MBT and attachment. The DBT principles of validation and acceptance are particularly important whilst consideration of the TCs principle of responsibility, equality, and community support is applicable.

### **Study Limitations**

There were some limitations with this study. Firstly, with a relatively small sample size, this qualitative study lacked generalisability as it employed a particular sample group whose views and perceptions may not have been representative of the wider clinical population. Grounded theory recognises that these views might change over time or in different contexts. For example, in this study participants might have made attributional errors or been unaware of or able to describe important processes in helpful service relationships. These might only have become understood after the interviews had been conducted which would affect the validity of the findings. In addition, most service-user participants were recruited from a TC setting rather than from a broad range of services so findings were specific to this group of participants and could not be generalized to a wider clinical population. Also, some service-user participants had co-morbid features that might have reduced validity of the results obtained. Furthermore, this study did not include a demographics questionnaire so limited knowledge of the sample population variance was available.



There may have been some biasing in the recruitment process. In particular, service-user participants were recruited via care-coordinators who may have been reluctant for certain service-users to be interviewed (e.g. if they had less helpful experiences). This study also relied on service-users already having a diagnosis of BPD rather than the researcher doing a diagnostic interview so the reliability of diagnoses was uncertain. Furthermore, some care-coordinators struggled to find potential service-users because of concerns that service-users were unaware of their diagnosis. It might have been more useful to have advertised this study so that people could contact the researcher directly.

A final limitation concerned the employed methodological analysis. Although grounded theory was a useful qualitative analysis tool for developing a theory, this theory was based on questions developed by the researcher who also analysed the data. This possibly reduced the validity of the results. However, biasing was minimised by use of a research diary, piloting the interview schedule, and from regular supervision support.

### **Clinical Implications**

Mental healthcare services need to model more healthy attachments to people with this diagnosis whereby consistent responses are maintained and services are more accepting of this client group. This will require training clinicians to have a better understanding so they can understand the meaning behind behaviours that are often viewed as manipulative or attention-seeking. Other NHS services such as emergency services and general practitioners might also benefit from such training.

This study suggests that more specialist services are required within the NHS. The psychological principles of DBT, MBT, or TCs are helpful and mental healthcare service providers need to consider these treatment approaches. This does not necessarily need to be a

whole service model but possibly a specialist team that can work with this client group and provide consultation to other teams struggling to manage individuals with BPD. In the long-term this could reduce costs associated with inpatient admissions and emergency service treatment. These specialist models are also helpful in that they share a model of understanding whereby a consistent approach to management of risk and understanding of the individual's difficulties is shared by team members.

Services also need to provide more consistent responses between clinicians and teams whereby information is shared across services so that inconsistent responses are reduced. Furthermore, mental healthcare service managers may need to become more flexible in relation to treating BPD. For example, if people are to continue being seen in CMHTs then services might need to consider providing longer, more intensive treatment that incorporates the principles of specialist psychological models outlined in this study. This will help promote the formation of trusting attachments with enough time for relational issues to be explored. Treatment endings also need to be more flexible with the possibility that people can be accepted back into services where necessary rather than rejecting them or placing people on waiting lists whereby crises may lead to self-harm to obtain care. Hence, by being more flexible, the cycle of over-dependency might be reduced.

Finally, further research is needed in this field. The results of this study give an important initial understanding of how helpful services relate to people with BPD. However, future research should consider gaining experiences of people from a more diverse population and range of service-settings, perhaps employing a mixed methodological approach with triangulation of measures. In particular, the model of helpful service relationships presented in this study needs further exploration. Further investigation of the helpful psychological

principles around attachment, responsibility, acceptance and validation is required to explore whether this model is reliable and valid.

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## **INDEPENDENT RESEACH PROJECT**

Section C

Critical Appraisal

**RACHEL GREGORY BSc (Hons) PGDip**

Word count:

4992 (plus 77 additional words)

A thesis submitted in partial fulfilment of the requirements of  
Canterbury Christ Church University for the degree of  
Doctorate of Clinical Psychology

JULY 2010

SALOMONS  
CANTERBURY CHRIST CHURCH UNIVERSITY

### **Summary of Research Findings**

The research aimed to provide a better understanding of how services relate helpfully to people with borderline personality disorder (BPD). Sixteen one-to-one, semi-structured interviews were carried out with qualified clinicians (n=8) and service-users diagnosed with BPD (n=8). The data was then analysed using grounded theory as developed by Corbin and Strauss (2008) and informed by Charmaz (2006).

From these findings, a psychological model based on attachment theory was developed. This suggested it was important for mental healthcare services to form a secure attachment to people with BPD. This included providing a safe, trusting, and nurturing environment that was accepting and validating. Giving more responsibility to service-users to manage their behaviours was deemed helpful since this reduced the likelihood of people developing insecure attachments. In contrast, when non-secure attachments developed this model suggested people are less likely to recover and more likely to continue having chaotic and disorganised relationships with services.

The following review will critically evaluate the research findings by firstly considering the methodological issues with this study. An examination of the quality assurance methods used in this study will then be discussed and the ethical issues encountered whilst conducting this research will be explored. The theoretical and clinical implications of this research will be presented, followed by future research ideas. Finally, personal reflections of the research process will be considered.

## **Methodological Issues**

### **Rationale for Grounded Theory Approach**

Grounded theory (GT) appeared the most suitable methodology since it was an under-researched area and no other psychological models had been developed to explain how services might relate helpfully and unhelpfully to people with BPD. As Henwood and Pidgeon (2003) suggested, by using GT open-ended research questions could be used to develop a theory that integrated the complex psychological processes regarding this.

GT was considered particularly useful since it uses a range of relevant sources (e.g. clinician and service-user participants) and provides rigorous, systematic, and specific procedures (such as coding and memo writing). This helps guarantee the development of theory based on the data being collected rather than being based on pre-existing theory. Other qualitative methodologies were considered but rejected since the aim was to produce a theory based on the data. For example, discourse analysis was rejected because it emphasises the language used by participants as a means of constructing their realities (Van Dijk 2001) whilst narrative analysis was rejected because it focuses on the ways individuals use stories to interpret the world (Lawler, 2002). Neither of these methodologies would have addressed the research aims adequately enough.

The other methodology that was seriously considered was interpretative phenomenological analysis (IPA). This is similar to GT as it is concerned with “exploring the lived experiences of participants” (Reid, Flowers, & Larkin, 2005, p. 20). However, unlike GT it is more concerned with personal meanings rather than generating a new theory about psychological interactions.

## **Epistemological Position**

Glaser and Strauss (1967) originally suggested that reality is discovered through empirical data. However, since then Mills, Bonner and Francis (2006) have suggested that a number of epistemological positions can be taken. For example, Charmaz (2006) has adopted the social constructionist approach whereby categories are constructed from the interaction of the researcher and the data that emerges.

A critical realist epistemological stance was taken with this research as this draws on positivist objectivity whilst considering participants actual experiences through constructionist subjectivity (Downward, 2006). As Robson (2002) explained, this aims at inverting theories that explain psychological mechanisms. For GT, this position fits with Strauss and Corbin's (2008) approach whereby the theory is constructed. This analyses the subjective realities of participants' experiences whilst acknowledging the context in which they are based (e.g. social contexts). It also accepts that the researcher's own experiences and beliefs will impact on the research process whilst allowing the researcher to become more aware of this natural biasing when analysing the data.

## **The Sample**

### **Participants.**

A particular advantage of this research study was that the two samples were heterogeneous, allowing for more generalisable results and firmer conclusions. They were recruited from various mental healthcare services within two NHS mental healthcare Trusts in Kent and London. This covered a wide geographical area and provided increased diversity in potential participants gained. All participants were recruited from services such as a therapeutic community, inpatient rehabilitation ward and community mental health teams.

With regards to service-user participants, two of the eight participants were male, which seemed representative of the gender differences often reported in the literature (e.g. Allen, 2004). A broad range of symptoms severity and length of mental healthcare service use involvement was also found. With regards to the clinician participants, a range of clinicians were recruited (e.g. nursing, psychiatry, psychological therapies) with varied clinical expertise. This included mentalization-based therapy, group approaches, psychodynamic therapy and medical-based approaches. Participants' lengths of clinical experiences varied too so a full spectrum of views could be sampled.

There were some disadvantages with both samples. In particular, there was a lack of ethnic diversity as all but one participant were of White British ethnicity. Although this was fairly representative of the areas the samples were gained from, it would have been beneficial to have participants from more diverse cultural backgrounds thus more representative of the general population. Another limitation was that many of the service-users were gained from a therapeutic community which has a very different ethos and culture to most other mental healthcare services. It is also generally regarded that TCs see the most severe cases of BPD since they are such costly and intensive resources. This possibly biased results since the themes that developed were mainly drawing on the experiences of service-users from this setting rather than other specialist service models. However, the TC involved in this study was not a residential service so possibly had fewer service-users deemed as severe. There were also some participants interviewed who subjectively seemed less severe and had coped relatively well prior to recent involvement from mental healthcare services.

### **Sampling technique.**

In line with GT, theoretical sampling was used for this study. As Charmaz (2006) explained, data is collected based on the emerging theory. After contacting a number of

mental healthcare services and presenting the research at team meetings, various teams agreed to participate in the study. This provided enough potential clinician participants for theoretical sampling to be undertaken. Clinicians were interviewed based on their particular experiences and to look for exceptions in the emerging theory (Willig, 2001).

Initially, it was difficult to recruit enough service-users since many teams were concerned that potential participants might not be aware of their diagnosis. Also, the researcher was constrained to care-coordinators identifying potential service-user participants limiting the control the researcher had in the sampling strategy used. This possibly biased the results since they might have only approached those service-users they deemed appropriate.

One service was particularly useful in providing a number of service-user participants. Once the first service-user had been interviewed and their experience had been a positive one, other service-users began to show interest and wanted to talk about their experiences. However, considering the difficulties in theoretically sampling, the interview questions were modified to be more specific to the emerging concepts. As Draucker, Martsolf, Ross, Rusk (2007) suggested, this is another way of theoretical sampling.

One participant did not fully fit the emerging model and was considered a negative case (Willig, 2001). Although this participant found mental healthcare services very helpful, she did not consider that some services might have been less helpful. For example, she believed more medicalised approaches such as medication and electroconvulsive therapy (ECT) were very helpful compared to the rest of the sample who felt this was particularly unhelpful. This participant appeared more unwell than most of the service-users interviewed. This was also her first experience of therapy, she had a co-morbid psychotic diagnosis, and was not as close to being discharged as other service-users interviewed. She also seemed less



interested in attachment experiences and very much believed her difficulties were biological and needed fixing medically. As Mays and Pope (2000) suggested, negative cases increase the validity of the research since it can be used to refine the analysis. The model developed focussed more on those who were able to reflect on both positive and negative experiences and who were closer to being discharged. As this negative case illustrated, for people who were further from recovery and were actively psychotic, they were possibly less able to hold a balanced view of treatment in mind.

As stated by Charmaz (2006), theoretical sampling should continue until no new information adds to the theoretical model. This is known as theoretical saturation. Alternatively, as Strauss and Corbin (2008) suggested, theoretical sampling is based within the context of a sample and that saturation might never be possible during research. With regards to the present study, by the last two interviews no new information was being generated suggesting saturation had been accomplished. Overall, 16 people were interviewed and the researcher felt confident that the model produced fitted most of the interview data.

### **The Interviews**

Within GT, interviews are recommended as the data collection method of choice and in particular, semi-structured interviews are useful since the structure can be modified throughout (Strauss & Corbin, 2008). This study employed in-depth semi-structured interviews but as this was the only method of data collection it possibly limited the richness of the data. A more triangulated approach using varying forms such as focus groups and archival data might have been advantageous. However, considering the time constraints of this project it was felt more beneficial to focus on recruitment and interviewing.

Although some people seemed anxious initially, people generally relaxed as the interview progressed and some commented afterwards that they had found the experience interesting. Some participants even mentioned that it had been helpful since they had not fully considered their experiences in this way before. Also, the participants seemed to value being asked to share their views, particularly as most service-users had felt devalued by services at some point. There were some participants who provided really in-depth and reflective interviews which possibly biased the results since their responses were possibly used more in the analysis.

Often participants gave more information than necessary for some of the interview questions. This proved particularly difficult during interviewing as the researcher did not want to invalidate people's experience yet needed to adhere to the research. Further into the research the interview questions were modified to account for questions that were particularly problematic (e.g. the icebreaker question that asked clinicians about their work experience).

### **The Analysis**

The GT analysis technique has been provided by both Strauss and Corbin (2008) and Charmaz (2006) they provided guidelines which were helpful in learning how to undertake GT. Initially, it seemed daunting to consider this approach since it required a great deal of analysis. It felt particularly worrying during the initial line by line coding when there appeared to be too many codes and whether any themes could realistically be developed from these. At this stage, even long pauses, verbal inclinations and emotional responses (e.g. laughter) were analysed and 81 categories were initially provided which were reduced to 26.

The coding process repeatedly had to be re-sorted and then recoded into sub-categories and categories. As more data was presented, earlier transcriptions and coding

required re-analysing. This process was particularly time consuming and felt difficult at times but it was important to be fully immersed in the analysis to understand the details of the data. Subsequently, after discussion with the supervisor and further analysis, 7 main categories and 24 subcategories were identified.

Finally, the computer programme, NVIVO, which is specifically designed for qualitative research was rejected for this analysis. Charmaz (2006) suggested such technologies may distance the researcher from their analysis since they are less involved with this. Consequently, it was felt important to become engrossed in the data enabling a more sensitive analysis to occur.

### **Quality Assurance Methods**

As suggested by Mays and Pope (2000), a number of techniques aimed at enhancing the integrity of the research were conducted to help ensure the validity and reliability of the research. Firstly, both interview schedules were piloted on two colleagues who provided very useful feedback about the questions used and how they felt about being interviewed (e.g. the colleagues commented on the relevance of questions asked and how they felt being interviewed).

The Transparency and reflexivity of the research was also provided by conducting an audit trail. This included providing an example of the original transcript that had been coded (appendix 12), a table showing how categories were developed (appendix 13), and two tables of the categories, sub-categories and open codes for service-users and clinicians (appendices 14 & 15). This was considered helpful for showing how the model developed. Throughout the research process, personal responses and potential biases to the data were continuously monitored by use of a research diary (appendix 16), memo keeping (appendix 17), and

supervision sessions. As Lincoln and Guba (1985) suggested these methods are particularly helpful for reflecting on personal responses. However, Charmaz (2006) commented that personal biases are going to inevitably influence the research but these methods help keep the transparency clear to the reader.

As suggested by Henwood and Pidgeon (2003), respondent validation is an important process in validating the data. A meeting was held with 3 service-user participants who judged the validity and accuracy of the main categories emerging from the analysis. Service-users generally agreed that the findings were representative of their views and felt satisfied with the validity of the analysis.

### **Ethical Considerations**

Ethical approval was gained from the NHS research and ethics committee and the British Psychological Society's code of conduct and ethics (2006) was adhered to throughout this research. No major ethical issues occurred whilst conducting this research and participants reported that they found it insightful.

At the start of the interview, the limits of confidentiality were explained to the participant. This included informing the participant that the interview would be confidential and that no one else would have access to their transcribed data, which would be password protected and kept on the researcher's password protected laptop. Although the issue of confidentiality were not raised in the service-user interviews, some clinician participants were concerned about confidentiality. This was particularly so when they had mentioned another colleague or described a service-user in-depth. These participants were concerned that if their quotes were used then people would be identifiable. The researcher reassured them that

this would not happen and where participants requested data to be omitted, the researcher abided by this.

Participants were informed that the research might cause some distress and this was achieved both through the use of participant information sheets and verbally by the researcher at the start of the interview. Participants were also informed that they could end the interview or take a break at any point. Throughout the interviews, the researcher tried to ensure participants felt comfortable and observed that the questioning was not upsetting for individuals. In particular, the researcher was very aware that service-users might have had traumatic experiences relating to unhelpful services that possibly felt upsetting. At the end of the interview, participants were de-briefed and the researcher checked that the participants were not upset. None of the participants said this was upsetting.

### **Theoretical Considerations**

The research findings seemed to confirm the theoretical literature based on the importance of fostering a secure attachment within services. In particular, participants found that having a containing and safe therapeutic attachment was vital. They identified the importance of forming trusting relationships that were consistent over time. This confirms the mentalization-based therapy (MBT) model regarding attachment theory. As Bateman and Fonagy (2008) identified, a secure attachment relationship is important for the individual to learn to mentalize. This is achieved by the therapist mirroring emotions and providing a consistent and secure base for safe exploration of relational problems.

Participants also felt that forming an attachment relationship whereby validation and acceptance occurred was helpful. This supported Linehan's (1993) dialectical behavioural therapy model of validation, acceptance and change. As Grossman and Grossman (2005)

found, when services use this dialectical balance it aids the attachment experience within therapeutic relationships.

The findings suggested that participants found that having firm boundaries and giving service-users more responsibility were important aspects of the relationship. As the therapeutic communities (TC) approach purports, attachment to the community is an important aspect of this model but so too is the sense of mutual dependence, responsibility for each other and the awareness of the self as having authority to change. These findings support Campling's (2001) conclusions that the intensity of the community, the peer support, clear boundaries, and the diversity of relationships in the TC helps the attachment relationship withstand aggression and risk that often occurs in other mental healthcare settings.

This study also found themes around unhelpful relationships with mental healthcare services. These were based around services where dysfunctional attachment relationships possibly occurred. In particular, participants identified that unhelpful dependencies occurred when treatment was sub-therapeutic confirming the findings from Koekkoek, Van Meijel, Schene, and Hutschemaeker's (2009) study. Participants suggested that unhelpful dependency occurred when people with BPD were more isolated. As Haigh (2002) found, they also have less social support in society so dependency on services is more likely.

Services were blamed for contributing to people's dependency suggesting that services reinforced dangerous behaviours by providing more care, and not taking positive risks with this client group. This study suggested that when services reacted in this way, it caused people to become overly dependent on services, maintaining dysfunctional relationships that were chaotic, untrusting, inconsistent, and lacked boundaries. This

confirmed McGowan's (2008) suggestion that it is often unhelpful for services to increase the care they provide in response to threats of self-harm as this fulfils the individual's need for care and prevents them from choosing to "get well". As Linehan (1993) asserted, this may inadvertently reinforce dangerous behaviours.

This study confirmed Haigh's (2002) argument that inconsistent services promote insecure relationships. As found in the present study, inpatient wards are particularly inconsistent and those deemed more powerful, such as consultant psychiatrists, are often experienced as inconsistent parental figures when they are less available. Service-user participants also identified that it was unhelpful when they felt disempowered by services. This was possibly because they were less likely to form a secure relationship since it might replicate abusive and controlling relationships from their pasts. As Brown (1992) found, the authoritarian, hierarchical context of mental healthcare treatment is re-traumatising and fosters insecure attachments to services.

Finally, services that were symptom-based and medicalised problems were found to be unhelpful and support Sampson's (2006) argument that these services are unhelpful since they place less emphasis on relational difficulties. In doing so, the present study suggested that such services possibly avoided forming a secure attachment relationship with this client group and hindered recovery.

### **Clinical Implications**

The current findings confirm recent research evidence (e.g. NICE, 2009; Bateman and Tyrer, 2002) which suggested that people with BPD are best treated in more specialist services. However, these findings suggested that people with BPD continue to be treated in services where secure attachments are less likely to occur and whereby there is a lack of

shared understanding, specialist skills, and where inconsistent and unhelpful responses are given (e.g. community teams and inpatient settings). Symptom-based, brief treatments were identified as unhelpful by participants since they did not emphasise relationship difficulties. For this to change, these findings suggest that services need to consider a more specialist model of working with this client group (e.g. DBT, MBT, or TC models). This does not necessarily need to be a dedicated service but a team that shares a unified, consistent, and shared understanding. This would encourage a more secure attachment to develop whilst helping clinicians take more positive risks since this could be shared by team members.

Such specialist approaches allow a relationship to develop over time and they are of such an intensity that allows for consistency between sessions to be promoted. They also utilise more than one therapist so a less dependent attachment relationship occurs, forming a hierarchy of attachment figures (Bowlby, 1982). Services should possibly consider these models since they value group based approaches enabling individuals with BPD to learn from others, form peer support, and have a sense of inclusion in services.

Although these models are more expensive (e.g. initial training, supervision costs, and requiring a team based approach) they are possibly cost-effective in the long-term. If people with BPD can form secure attachments with services then they are possibly less likely to form chaotic and over-dependent relationships with services. Not only will service-users be provided the opportunity of living a more fulfilling life but the additional costs associated with treatment at emergency services and inpatient stays should be reduced. Also, once trained, team members such as clinical psychologists could train other clinicians in using the model and providing consultative work for other teams who are struggling with helping people with BPD.



These findings suggested that more training and supportive supervision is required in non-specialist services. Clinicians need to be provided with a better understanding of BPD, their attachment difficulties and why they behave in the way they do. In particular, clinicians need to be mindful of how people with BPD might split teams, project difficult emotions, and self-harm as a means of trying to gain further help. This might increase empathy and reduce the pathologising that exists in such teams. Additionally, group supervision would be beneficial providing a reflexive space for sharing difficult emotions as a team.

Finally, whilst service-users who participated in this study reported that a diagnosis of BPD was helpful in understanding their difficulties the semantics of the term „borderline personality disorder“ were commonly reported as being stigmatising and pathologising. It would seem that services should consider providing this diagnosis to people rather than colluding with the system and avoiding disclosure. However, this diagnostic label possibly needs to be changed to a less stigmatising and more helpful diagnostic label.

### **Future Research**

This research has helped to consider how mental healthcare services relate to people with BPD and provides a useful initial understanding of the psychological processes involved. However, this research is limited in some areas. This included the lack of participants from different ethnicities so future research should consider what people from more diverse backgrounds find helpful. Also, there was a lack of specialist services involved, particularly regarding service-user participants so this might have biased the results. It would be useful to expand this research and interview people from other specialist services (e.g. MBT and TCs) to see if the themes identified in this research can be generalised to other services. It might be helpful to consider interviewing people who have been diagnosed with

other personality disorders to compare what they consider helpful service relationships. Also, this research could be repeated in forensic services since many people with personality disorders are seen in these services. By examining other services and including other personality disorder diagnoses, would add to the validity and reliability of findings in this study.

As another method of researching the model presented in this study, it might be helpful to quantitatively research this using a between-participants design. This could compare outcomes of people with BPD from a less securely attached service (e.g. community team) versus a securely attached service (e.g. specialist service). This might include following up service-users and possibly asking people via questionnaires what was helpful or unhelpful about these services and whether they felt they had recovered or needed more help. It might also be helpful to match service-users with clinicians to provide more of a comparison between the beliefs held by clinicians as compared with those of service-users. These research methods would provide further evidence that might substantiate the present findings.

It is important to note that some themes that emerged in the research were not included in the final model since there were too few participants who agreed on these themes or they were not specifically relevant to the research question being asked. For example, during the research some clinician participants reported that older service-users who were more entrenched in the system possibly struggled to recover. However, they generally felt younger service-users were easier to treat. It might be helpful to research this further and consider whether age and amount of services involvement effects what is deemed as helpful services for this client group as compared to younger people. It would be useful to explore

whether there are differences in what individuals consider helpful so enabling better service design.

A final research area would be to qualitatively interview people about their experiences of being given a diagnosis of BPD. This could provide further evidence of whether or not the diagnostic label needs re-naming.

### **Personal reflections**

#### **Considering a Topic Area**

I was originally drawn to this topic because of clinical experiences of working with people diagnosed with BPD. I had first-hand experience of seeing the stigma and lack of positivity with this client group and felt I wanted to understand more about this. Based on my experience, I firstly decided to explore the stigma associated with BPD. After initially researching this area and struggling to identify a useful research question I rejected this idea. On discussing potential research questions with my supervisor, I became very interested in how people with BPD recover. However, after further consideration I finally decided it would be interesting to research how services are helpful for this client group since I had noticed that services often behaved very differently to many of the governing principles of the psychological approaches I had experienced.

I had always considered that I would use qualitative methodology since I had mainly used quantitative methodology techniques in past research projects and I felt that this methodology would be very interesting and also challenge me. However, I was unsure what technique to use. As the research question developed, I became more convinced that GT would be the most appropriate tool.

On using this methodology, I found it really interesting how GT methods produced such in-depth results that would be impossible with quantitative methodologies. This felt meaningful and allowed participants' voices to be heard in an area of research where so often this is not the case. I feel that I have become competent in using this methodology and have learnt a great deal about GT techniques such as constant comparison and line by line coding. This has enabled me to feel more confident about using this approach and I would certainly consider using this methodology again in the future.

I also considered interviewing people with a variety of personality disorders as I was concerned that I might not find enough participants. This was later disregarded since it was felt that this sample might be too varied to provide a useful model of what was helpful for people.

#### **Awareness of researcher biasing.**

Having worked with people diagnosed with BPD I was very aware of the negativity that surrounds this diagnostic label. In particular, I had experienced how multi-disciplinary teams often reacted to people with BPD as though they were untreatable and I found this quite frustrating. Having previously worked on inpatient settings as an assistant psychologist and an activities co-ordinator I had first-hand experience of how the ward environment seems quite harmful for people with this diagnosis. I was aware of the splitting that occurred and felt these environments were often abusive and hostile.

Furthermore, I have been an NHS mental healthcare service-user myself. This has particularly shaped my experiences of services but from a service-user perspective. My experiences of this have been very mixed. For example, I have found it helpful being provided with support and being given treatment options. In particular, having a rapid

response at times of distress has been really useful and containing. However, I have struggled with the inconsistencies in clinicians seen, staff lacking understanding, the lack of continuity between appointments, and the powerful sedation effects from medication. I often felt hopeless about how NHS mental healthcare services could help me. In consideration of this, I am aware that my experiences have been fairly negative compared to my experience of private therapy.

Consideration of all these factors, I became extremely mindful my own assumptions about services. I was particularly aware of my biasing about services being rejecting and how my own experience have shaped my beliefs regarding this project. The use of a reflective diary helped me consider my biases relating to this research but I felt that some of my experiences still resonated with what people described whilst interviewing. This sometimes made it harder to remain objective although taking a critical realist stance I was able to acknowledge my biasing and my role in the analysis process.

### **Reflections of the Findings**

These findings seemed to really fit with my own personal experiences of mental healthcare services although I was surprised by some the results. I thought participants would generally think that medication was helpful so it was interesting that they too considered this problematic and unhelpful. I found it was useful to hear so many service-users describe helpful clinicians as being those who could really challenge them. I thought this was really helpful and I personally felt I could reflect on this within my own clinical work. It was also interesting and surprising how so many of the key themes were shared by both service-users and clinicians. I did not expect this to happen and it seems helpful to

consider that people with BPD share similar beliefs and are able to really reflect on their past experiences (both positive and negative).

Originally, I thought it would be very difficult to engage people with BPD, especially since many service-users do not have this diagnosis given to them formally. However, participants engaged really well and seemed to truly value being asked for their opinions. At times I found these interviews very powerful and moving as a many of the participants recalled some very upsetting situations. I thought it was extremely courageous how individuals talked about their experiences so openly with me and I feel this was extremely beneficial to the research.

Finally, although I tried to capture participants' experiences as best I could within section B it was difficult since the word limit meant few quotes could be used. I was concerned this would not truly capture their views and hope that by including some more examples in the appendices this will help the reader gain a better understanding.

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## **INDEPENDENT RESEARCH PROJECT**

### **SECTION D**

### **APPENDICES OF SUPPORTING MATERIALS**

JULY 2010

SALOMONS  
CANTERBURY CHRIST CHURCH UNIVERSITY

**Appendix 1: Research & development approval letter**

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**Appendix 2: Research and development approval letter**

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**Appendix 3: Approval letter from the chair of ethics panel with full approval**

*This has been removed from the electronic copy*

**Appendix 4: Invitation letter  
for clinicians****Research Project: Borderline personality disorder and helpful service  
characteristics: Service-users' and clinicians' views**23<sup>rd</sup> September 2009

Dear clinician,

My name is Rachel Gregory and I am a third year clinical psychology doctorate trainee. As part fulfilment of my Doctorate I am required to carry out a piece of research for Salomons, Canterbury Christ Church University, Kent and I am looking for potential participants.

The main aim of this study is to generate a better understanding of what services do that are helpful for people diagnosed with borderline personality disorder. I am interested in your views and experience of this.

This study is supervised by Dr John McGowan, clinical psychologist and clinical tutor at Salomons training course and Dr Ruth Chester, a clinical psychologist for Oxleas NHS Trust.

If you would like to participate in this study then this will involve being interviewed so that I can understand what factors you feel have been helpful in treating people who have been given a diagnosis of borderline personality disorder. The interview will last approximately an hour and a half and will be audio taped. Any information recorded in this study will be kept strictly confidential. All identifiable information (such as names, addresses, dates, and other details) will be disguised from the information so no one other than myself can identify the participants. It will also be helpful if participants can let me know if there are any other details they would like disguised so I can protect anonymity.

Further information about the study and what you should expect can be found in the enclosed participant information sheet. It is entirely your decision whether or not you take part in this research and your decision to take part in this study will not affect your treatment in any way.

If you feel you would like to participate in this study, then please fill in the participant consent form attached. Alternatively, if you require further information before deciding or would like to talk to me about this study then please contact me on . I will return your call as soon as possible.

Thank you so much for your time and I look forward to hearing from you.

Yours sincerely,

**Rachel Gregory**  
**Trainee Clinical Psychologist**

## Appendix 5: Clinicians information sheets



### **Borderline personality disorder and helpful service characteristics: Service-users' and clinicians' views**

#### **Introduction**

You are invited to take part in a research study being carried out in part fulfilment of a Doctoral Degree in Clinical Psychology at Salomons, Canterbury Christ Church University, Kent.

Before deciding whether to take part it is important for you to understand why the research is being conducted and what it will involve. Please read the following information carefully and if you need more information, please contact me, Rachel Gregory, on ... .

#### **What is the title of the study?**

Borderline personality disorder and helpful service characteristics: Service-users' and clinicians' views.

#### **What is the purpose of the study?**

This study hopes to identify what services do that is most helpful for people diagnosed with borderline personality disorder. It is hoped that this might increase our understanding of how services are useful, but also encourage further research into this area.

#### **Why am I being asked to take part?**

You are being asked if you would like to take part because you have experience of working with people with a diagnosis of borderline personality disorder that could benefit this study. You will have an understanding of what services do that are helpful for people with this diagnosis and I am interested in your view. For this study I will also be asking both service-users and clinicians about what they think is most helpful.

#### **What does the study involve?**

I will interview you about what you believe services do that are helpful for people with a diagnosis of borderline personality disorder. The interview may take up to an hour and a half and will be audio taped. This will be confidential and all information will be kept securely and anonymised.

#### **Do I have to take part?**

No you do not have to take part and it is entirely your decision. If you decide to participate in this study you are still free to withdraw at any time and without giving any reason.

#### **What will happen if I agree to take part?**

If you agree to take part the following will happen in this order:

1. I will contact you by telephone to arrange a convenient date to meet for the interview.
2. The interview will last approximately 1.5 hours and will be based at your place of work. During the interview I will ask you about your views on what services do that are helpful.
3. Time will be allocated at the end of the meeting to answer any questions you may have.
4. You will be given the opportunity to comment on the findings of this study.
5. I expect to complete this research by July 2010. A summary of the research findings will be sent to you unless you say otherwise.



**Will I find the interview distressing?**

I hope this interview will not be distressing as it is focussing on your professional opinion of what helps people with this diagnosis. However, if you do become upset I will be sensitive to such a possibility and will make sure you are comfortable about continuing with the interview. If necessary I shall end the interview at your request and help you consider accessing appropriate services.

**Will my taking part be kept confidential?**

Information collected in this study is kept confidential. All identifiable material (for example names and addresses) is disguised from the information so no one other than myself, the lead researcher, can identify you. I will disguise all personally identifying details in any quotations used in the research and your consent for any quotations used will be sought.

**Why does the interview have to be audio taped? How confidential will this be?**

This study requires accurate recordings of what is said in the interviews. The best way of achieving this is by audio taping. I will transcribe the audiotapes of the interviews to written form within two weeks of the interview taking place. The tapes will then be erased. Any information in the transcripts that could identify you will be changed to protect anonymity. Your transcripts will be given an identification number, which only I will know corresponds to you. Your interview material will be anonymised and stored on a password-protected computer.

**Are there any circumstances where you would pass on information about me?**

If during the interview you reveal information that suggests you or someone else might be at risk of serious harm then I will be obliged to pass this information on to an appropriate person.

**What happens with the results of the research?**

In Spring 2010 you will receive a summary of the main findings of the study, unless you say otherwise. You may wish to comment on this so that I can get an idea of how well my conclusions fit your experiences. The study will then be submitted for examination in July 2010 and later published in a professional journal for the wider psychology community.

**Who do I contact for more information?**

For any further information please contact me on ... . If I am unable to answer your call, please leave a message stating that you are calling about the research project. Please leave a contact number and I will get back to you as soon as possible.

**I have decided to take part in the study. What do I need to do now?**

Please call me on ... so we can arrange a convenient time to meet for the interview. If I have not heard from you within a month of receiving this letter I will assume you do not want to take part in this study.

Thank you for taking the time to read this information sheet. If you have decided to take part in this study I would like to thank you in advance for your contribution.

Yours sincerely,

Rachel Gregory

**Trainee Clinical Psychologist**

**Appendix 6: Invitation letter  
for service users****Research Project: Borderline personality disorder and helpful service  
characteristics: Service-users' and clinicians' views**23<sup>rd</sup> September 2009

Dear service user,

My name is Rachel Gregory and I am a third year clinical psychology doctorate trainee. As part fulfilment of my Doctorate I am required to carry out a piece of research for Salomons, Canterbury Christ Church University, Kent and I am looking for potential participants.

The main aim of this study is to generate a better understanding of what services do that are helpful for people diagnosed with borderline personality disorder. I am interested in your views and experience of this.

This study will be supervised by Dr John McGowan, clinical psychologist and clinical tutor at Salomons training course and Dr Ruth Chester, a clinical psychologist for Oxleas NHS Trust.

If you would like to participate in this study then this will involve being interviewed so that I can understand what factors you feel have been helpful in your treatment relating to your diagnosis of borderline personality disorder. The interview will last approximately an hour and a half and will be audio taped. Any information recorded in this study will be kept strictly confidential. All identifiable information (such as names, addresses, dates, and other details) will be disguised from the information so no one other than myself can identify participants. It will also be helpful if participants can let me know if there are any other details you would like disguised so I can protect anonymity.

Further information about the study and what you should expect can be found in the enclosed participant information sheet. It is entirely your decision whether or not you take part in this research and your decision to take part in this study will not affect your treatment in any way.

If you feel you would like to participate in this study, then please fill in the participant consent form attached. Alternatively, if you require further information before deciding or would like to talk to me about this study then please contact me on . I will return your call as soon as possible.

Thank you so much for your time and I look forward to hearing from you.

Yours sincerely,

**Rachel Gregory**  
**Trainee Clinical Psychologist**

**Appendix 7: Service user  
information sheets****Borderline personality disorder and helpful service characteristics: Service-users' and clinicians' views.****Introduction**

You are invited to take part in a research study being carried out in part fulfilment of a Doctoral Degree in Clinical Psychology at Canterbury Christ Church University, Kent.

Before you decide whether to take part it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and discuss it with someone close to you if you wish. If you need more information, please contact me, Rachel Gregory, on .

**What is the title of the study?**

Borderline personality disorder and helpful service characteristics: Service-users' and clinicians' views.

**What is the purpose of the study?**

This study hopes to identify how services are helpful for people diagnosed with borderline personality disorder. It is hoped this might improve our understanding of useful service characteristics for people with this diagnosis.

**Why am I being asked to take part?**

As you are aware, you have been given a diagnosis of borderline personality disorder and have been receiving help from the NHS relating to this diagnosis. You may feel that you are coping somewhat better lately. Your experiences of what has helped you feel like this are important for this research. For this study I will also be asking both service-users and clinicians about what they think is most helpful.

**What does the study involve?**

I will interview you about what has helped you so far. The interview may take around an hour and will be audio taped. This will be confidential and all information will be kept securely and anonymised.

**Do I have to take part?**

No you do not have to take part and it is entirely your decision. If you decide to participate in this study you are still free to withdraw at any time and without giving any reason. If you decide you do not want to participate, or you want to withdraw from the study, this will not affect your present or future involvement with mental health services.

**What will happen if I agree to take part?**

1. I will contact you by telephone to arrange the interview.
2. The meeting will be 1.5 hours long and will be based where you are seen for treatment.
3. Time will be allocated at the end of the meeting to answer any questions.
4. You will be given the opportunity to comment on the findings of this study.
5. I expect to complete the research by July 2010. A summary of the research findings will be sent to you unless you say otherwise.

**Will I find the interview distressing?**

I hope this interview will not be distressing as it is focussing on what has helped you. However, the interview may bring up some more negative experiences that would still be really helpful to hear about. Although I am not in a position to offer any significant help we can think about whom you might contact. I will also have an information sheet listing services you may find helpful. If you do become upset I will be sensitive to such a possibility and will make sure you are comfortable about continuing the interview. You may choose to take a break during the interview and we can continue at your request. However, you may decide to end the interview if you feel upset and I will not include your data unless you say otherwise.

**Will my taking part be kept confidential?**

Information collected in this study is kept confidential. All identifiable material (e.g. names and addresses) is disguised so no one other than myself, the lead researcher, can identify you. I will also disguise all personally identifying details in quotations used in the research and your consent for any quotations used will be sought prior to being included in the report.

**Why does the interview have to be audio recorded? Will this be confidential?**

The type of analysis used in this study requires accurate recordings of what is said in the interviews. The best way of achieving this is by audio taping. I will transcribe the audiotapes of the interviews to written form within two weeks of interviewing. The tapes will then be erased. Any information in the transcripts that could identify you will be changed to protect anonymity and stored on my password-protected computer.

**Are there any circumstances where you would pass on information about me?**

If during the interview you revealed information that suggested you or someone else might be at risk of serious harm then I would be obliged to pass this information on to an appropriate person.

**What happens with the results of the research?**

In Spring 2010 you will receive a summary of the main findings of the study, unless you say otherwise. The study will then be submitted for examination in July 2010. At a later stage it is likely that these findings will be published in a professional psychological journal.

**Who do I contact for more information?**

For any further information please contact me on ..... . If I am unable to answer your call, please leave a message stating that you are calling about the research project.

**I have decided to take part in the study. What do I need to do now?**

Please contact me on .... or let your care manager know so they can contact me. If I do not hear from you within a month I will assume you do not wish to take part.

Thank you for taking the time to read this information sheet. If you have decided to take part in this study I would like to thank you in advance for your contribution.

Yours sincerely,  
Rachel Gregory  
**Trainee Clinical Psychologist**

**Appendix 8: Consent form**



**CONSENT FORM**

Title of project:

**Borderline personality disorder and helpful service characteristics: Service-users' and clinicians' views**

Name of researcher: **Rachel Gregory**

Please read each statement below and tick the appropriate boxes if you are willing to give your consent:

- ☐ I understand that my participation in this research study is voluntary and I am able to withdraw from the study at any time without giving my reason and without my healthcare or legal rights being affected.
- ☐ I am happy to be contacted on the telephone number given to arrange a time to be interviewed.
- ☐ I agree to have my interview audio taped. I understand that this tape will be transcribed and anonymised when placed onto a password-protected computer and that this tape will then be erased within 48 hours of my interview.
- ☐ I agree that quotations taken from my interview may be used in this study and in subsequent publications. I understand that all quotations will be anonymous and I will not be identifiable from them. I also understand that verbal permission will be sought prior before any of my quotations are used in this study.
- ☐ I agree to participate in the above study

My Contact telephone number is \_\_\_\_\_ if you have any further questions or concerns.

Name: .....

Signature: .....

Date: .....

**Appendix 9: Clinician interview schedule****Semi-structured interview: clinicians**

Hello, my name's Rachel Gregory, and I am a trainee clinical psychologist. I will be interviewing you today if you decide you would still like to take part [general conversation to relax the interviewee].

Firstly, thank you for showing an interest in taking part in this study today.

I just need to run through a few details with you first of all to check you are still happy to participate in this study and then I will need to ask you to sign a consent form to confirm this. Is that OK?

As you may recall, this study is about what services do that is helpful for people with a diagnosis of borderline personality disorder (BPD).

You have been asked if you would like to participate in this study because you have experience of working with people with this diagnosis that I feel will be really helpful in this project. I am particularly interested in your experience of working with such clients and how you and your service might have helped people with this diagnosis. I will ask you some questions relating to this. This should last for about an hour but this might finish earlier.

This interview is entirely voluntary so if at any stage you feel you want to end the interview, please let me know and I will terminate the interview. Subsequently, your data will not be included in the research.

As you may remember from the information sheet I gave you, all personal details will be anonymised when the interview is transcribed. I will code this interview so only I will know which interview was yours. All transcribed data will be kept on a password protected PC that only I know the password for.

Do you have any questions before we begin?

Great, so would you still like to participate in this study? [Ask to fill in consent form if agrees to participate]

\*\*\*\*\*START TAPE RECORDING\*\*\*\*\*

The following broad questions will be used but further, more specific, questions will be asked as guided by the interview responses.

**Borderline personality disorder background:**

1. First of all, please can you tell me a bit about your experience of working with people with a diagnosis of BPD?
  - a. How many years have you worked in this field?
  - b. What type/s of service/s do you work for?
2. How do you feel about working with such clients? Please explain.
  - a. Is it particularly difficult work?
  - b. Do your clients stir up different emotions for you? Please explain.
  - c. Is this work rewarding or enjoyable? Please explain.

3. What do you realistically hope to achieve when you see such clients?
  - a. What are the immediate achievements you hope for when seeing clients with a PD?
  - b. How optimistic are you about short term gains?
  - c. What do you hope will be the long term gains?

**Own clinical work and defining what is helpful**

1. If you were to define what is helpful for people with this diagnosis what would you include?  
 Prompts for further questioning: reduce self-harm, social functioning improves, no longer diagnosed with PD, less service involvement, less risky behaviour.
2. From your own experience, how do you know when your work has been helpful for someone with a diagnosis of BPD?
3. Can you tell me about a time when your work has been a success with a client with a diagnosis of BPD?
  - a. How do you know it was a success?
  - b. What did you specifically do to help this person?
  - c. How did you feel towards your client?
  - d. What was your relationship like with this person?
  - e. What aspects were important about your client?
  - f. What was important about the service you were/are in?
  - g. What have you learnt from this experience?
4. Can you tell me about a time when your work was less helpful?
  - a. How do you know it was less helpful?
  - b. What did you specifically do that was not so helpful for this person?
  - c. How did you feel towards your client?
  - d. What was your relationship like with this person?
  - e. What aspects were important about your client?
  - f. What was important about the service you were/are in?
  - g. What have you learnt from this experience?
5. What are your beliefs about what is helpful for people with a diagnosis of BPD?
6. What about more generally. What has been helpful about the work you have done with other clients with a diagnosis of BPD?
7. Are there times when you feel you are not been able to help someone? Please explain.
8. In general, what have you learnt about what is helpful and not so helpful that you do?

**Service related questions & helpfulness**

1. In general, what has been helpful about the work your service has done for people with a BPD?  
(Identify team working, engagement, managing risk, type of PD, supervision)
2. What do you think needs to change with current services?
3. How do you envisage the ideal service would look?

\*\*\*\*\*STOP TAPE RECORDING\*\*\*\*\*

**De-brief**

Do you have any further comments or questions you would like to ask me?  
(Check the participant is not feeling distressed or worried by the interview)

Thank you for participating in this study today.

[End the interview]



## **Appendix 10: Service user interview schedule**

### **Semi-structured interview – service-users**

Hello, my name's Rachel Gregory, and I am a trainee clinical psychologist. I will be interviewing you today if you decide you would still like to take part [general conversation to relax the interviewee].

Firstly, thank you for showing an interest in taking part in this study today.

I just need to run through a few details with you first of all to check you are still happy to participate in this study and then I will need to ask you to sign a consent form to confirm this. Is that OK?

As you may recall, this study is about what services do that is helpful for people with a diagnosis of borderline personality disorder (BPD). I am particularly interested in what you think has been helpful about the mental health services you have received.

You have been asked if you would like to participate in this study because you have experience of mental health services that I feel will be really helpful in this project. I will ask you some questions about what has helped you from your experience. This should last for about an hour but this might finish earlier.

This interview is entirely voluntary so if at any stage you feel you want to end the interview, please let me know and I will terminate the interview. Subsequently, your data will not be included in the research.

As you may remember from the information sheet I gave you, all personal details will be anonymised when the interview is transcribed. I will code this interview so only I will know which interview was yours. All transcribed data will be kept on a password protected PC that only I know the password for.

Do you have any questions before we begin?

Great, so would you still like to participate in this study? [Ask to fill in consent form if agrees to participate]

\*\*\*\*\*START TAPE RECORDING\*\*\*\*\*

### **Borderline personality disorder background:**

1. First of all, do you remember when you were first told you had this diagnosis?
  - a. How long ago was this?
  - b. What did you feel about the diagnosis?
  - c. Do you think this diagnosis has affected your treatment at all? Please explain.
2. What type of mental health services have you received until now?
  - a. What has your experience been of these services?
  - b. What has been the most helpful? Please explain.
  - c. What has been the least helpful? Please explain.

**Experiences that were unhelpful**

1. Please can you tell me about a time when services have been less helpful?
  - a. What did the service do that was unhelpful?
  - b. How do you know it was not helpful?
  - c. How do you think this affected you?
2. What about your role? Have you ever been offered help but not felt able to use it?
  - a. What beliefs or thoughts did you have?
  - b. Did you change how you behaved at all?
  - c. What did you hope for from services at this time in your life?
  - d. Were there other aspects of your life that were contributing to you not wanting, or not feeling able to change?
3. Can you tell me about your experience of a professional/s that was not helpful?
  - a. What did s/he do?
  - b. What was their approach like?
  - c. Can you tell me a bit about your relationship with that person/s?
  - d. How were they different to other professionals you have met?
  - e. How do you know they did not help you recover/feel better?
  - f. What aspects or personal qualities effected how helpful they could be?
  - g. How did you feel towards him/her?
  - h. Can you tell me how much you felt you needed this person?
  - i. What have you learnt from this experience?

**Positive experiences of services and professionals**

1. How have mental health services been particularly helpful for you?
2. Which service has been the most beneficial and can you explain why that was?
  - a. What did the service do to help you?
  - b. How do you know it helped you?
  - c. What changed for you?
3. What do you believe your role was in feeling better?
  - a. What attitudes or thoughts did you have?
  - b. Did you change how you behaved?
  - c. Were there other aspects of your life that helped you to feel better?
4. Can you tell me about your experience of a professional/s that has helped you?
  - a. What did s/he do?
  - b. What was their approach like?
  - c. Can you tell me a bit about your relationship with that person/s?
  - d. How were they different to other professionals you have met?
  - e. How do you know they helped you recover/feel better?
  - f. What aspects or personal qualities were important about this person?
  - g. How did you feel towards him/her?
  - h. Can you tell me how much you felt you needed this person?
  - i. What was this person like around boundaries? (explain what I mean if necessary)
  - j. What have you learnt from this experience?

**Thoughts about discharge/recovery**

1. How do you feel about possibly reducing your contact with services?
2. What has helped you get to this point?
3. Do you have any particular anxieties about reducing your contact with services? (if not mentioned above)
4. Have there been other factors, other than what services have helped with, that have contributed to this? This might include family, relationships, work or anything else.

**Services in general**

1. In general, what have you learnt about what has been helpful and not so helpful?
2. What do you think needs to change with current services?
3. What would your ideal service look like?

\*\*\*\*\*STOP TAPE RECORDING\*\*\*\*\*

**De-brief**

Do you have any further comments or questions you would like to ask me?  
(Check the participant does not feel worried or distressed by the interview)

Thank you for participating in this study today.

[End the interview]

**Appendix 11: Table of clinicians and service-users categories and subcategories**

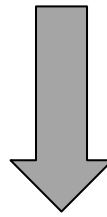
<b>Primary category</b>	<b>Category</b>	<b>Sub-categories</b>	<b>Number of participants</b>
<b>Healthy relationship</b>	<b>Secure attachment</b>	Clinicians as safe parental figures	16
		Boundaried & challenging clinicians	15
		Establishing trusting relationships	15
		Consistency in relationships	15
	<b>Acceptance &amp; validation</b>	Sense of belonging	15
		Being listened to and understood	15
		Belief and respect in the individual	11
	<b>Risk management (clinicians only)</b>	Shared inter/intra service approach	8
		Clinicians taking positive risks	7
		Giving responsibility to service-users	8
<b>Unhealthy relationship</b>	<b>Rejection and invalidation</b>	Feelings of rejection when discharged	16
		Exclusion and abandonment	15
		Feeling judged and misunderstood	13
		Service-users not being listened to (SU only)	7
	<b>Dependency</b>	Wanting to be cared for by services	13
		Isolation and dependency (SU only)	6
		Blaming services for dependency (clin's only)	8
	<b>Symptom management</b>	Medication & over-medication	15
		Patching up symptoms	15
	<b>Disempowerment</b>	Ward environment and abuse	11
		Unhelpful power differences (SU only)	6
		Hiding diagnosis from service-users	13

## **Appendix 12: Example transcript including initial coding and coding**

*This (pp.s133-147) has been removed from the electronic copy*

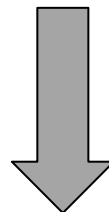
**Appendix 13: Category development**
**Initial provisional codes for collated clinicians and service-users data (number of codes: 81)**

Secure attachment	Nurturing and caring	Sense of containment	Providing a secure base	Parental figures	Clinician as good object
Being boundaried	Challenging services or clinicians	Maternal care and being looked after	Limit setting	Fixed / rigid relationship approach	Relationship consistency
Continuity of relationship	Honesty in providing care	Trusting relationships	Community feeling	Group membership helpful	Acceptance in services
Support and friendship forming	Sense of belonging	Sense of services wanting to find out more	Listening and being listened to	Feeling that services understand	Sense of respect
Importance of not pathologising people	Having belief in the SU	shared responsibility to risk within the team	Working with a shared model of understanding	Collaborative working	Sharing support as staff team
Supervision within teams & reflecting	Positive risk management	Not placing people in hospital	Sense of not over reacting or being too cautious	More responsibility given to SU	Sense of client's own accountability in managing symptoms
Discharge and rejection	Feeling abandoned when discharged	Sense of exclusion with services	Abandonment from services	Sense of loss and isolation post discharge	Judging service users
Feeling that not accepted	Being pathologised	Sense that label is insulting	Sense of services mis-understanding	Sense that clinicians lack skills/ understanding	Sense that services ignore people
Feeling of not being listened to	Dependency and wanting care from services	Services becoming the main support for people	Blaming services for dependency	Isolation and dependency	Sense that lack of social support leads to dependency
Patching up symptoms	Short-term management of symptoms	Longer term relational difficulties not considered	CBT only patching up symptoms	Over medication	Being given a variety of drugs
Sense that medication is unhelpful	Medication not helping relational difficulties	Services needing to take responsibility for over-dependency	Sense that inpatient wards are abusive	Abuse of care	Overly controlling environments seen as abusive
Power differences problematic	Strict doctor-patient relationship unhelpful	Sense that hierarchical services unhelpful for SU	Empowerment through diagnosis sharing	Disempowered when diagnosis not shared	Sense that diagnosis is often not shared
Contradictory messages	inconsistent responses	MDT often unhelpful	Not making false promises	Medical model problematic	Self-harming to be cared for
Sharing similar experiences	empathising	Seeing the same clinician over time as helpful			



**These were tightened to 26 categories of which some later became the final sub-categories**

Secure attachment (4)	Safe parental figures (3)	Setting boundaries and being appropriately challenging (4)	Relationship consistency and continuity (3)	Establishing trusting and honest service-client relationship (3)
Sense of belonging and acceptance (6)	Being listened to / understood (4)	Respecting the individual (3)	Shared / collaborative model (4)	Taking positive risks (3)
Giving responsibility to service-users (2)	Sense of rejection when discharged (2)	Exclusion and abandonment (3)	Sense of diagnosis being judged (3)	Sense of being misunderstood (2)
Sense of services ignoring people with BPD (2)	Wanting to be cared for by services (3)	Isolation and dependency (2)	Symptom management (5)	Blaming services for dependency (2)
Medication unhelpful (2)	Overmedicating (2)	Abuse and power (3)	Diagnosis sharing (3)	Unhelpful power differences (3)
Inconsistent responses (3)				



**Leading to the final seven categories**

Secure attachment (5)	Acceptance and validation (3)	Shared responsibility & risk (4)
Rejection and invalidation (5)	Feelings of dependency (3)	Symptom management (3)
Disempowerment (3)		

**Appendix 14: Categories, sub categories, open codes and quotes for clinician participants**

Category	Sub-category	Open codes	Example quotes
<b>Secure service-client attachment</b>	Clinicians as safe parental figures	Parental figure Mother/father figure Sense of secure attachment Feeling of looking after or caring for others Caring others Clinicians as good objects Containing clinician Secure base from which to explore the world Sense of safety or security Sense of Nurturing Returning after discharge as formed a secure attachment	<ul style="list-style-type: none"> <li>• I'm the kind of tough father who has given her a difficult message.</li> <li>• It's like being a parent sometimes...as they grow up they become more independent, slowly growing up and becoming more mature.</li> <li>• I have entered her inner world as a good object, consistent, caring object, which she can use, like one might, the synthesis of a mother.</li> <li>• When she came here she used to look out for me every day because she didn't feel secure unless I was here. I suppose I'm like a father figure for her.</li> <li>• Creating a secure attachment in a sense or helping someone form a secure attachment either to a service or to a clinician that can be productive and rewarding.</li> <li>• She had a secure attachment to me and possibly similar to a maternal relationship.</li> <li>• The development of a safe container and a place where you get attached which is benign and helpful where people can start to dare to explore their feelings, there individual feelings about themselves and about the past.</li> <li>• Having a trusting kind of a safe relationship with the client and that can contain a lot of the acting out, fear and anxiety that goes with it.</li> <li>• We offer a sort of containment for them. I think we offer an opportunity to explore within a safe setting the lifelong difficulties that they have in relationships and their bad internal objects if you like.</li> <li>• The service becomes a secure base in which people can go off and explore their lives but if there is a crisis they can come back to somewhere that they feel is safe to someone that they know and can trust and where they will feel a constant and stable response that doesn't vary too much.</li> </ul>



			<ul style="list-style-type: none"> <li>• What is wrong with somebody who hasn't really had much safety in their life finding a service that offers some degree of safety that they can rely on? Is that dependence? Is that again something more secure?</li> <li>• It's finishing a piece of work, going off and living away from services and if things get tough then they can come back to their secure base.</li> </ul>
	Establishing trusting relationships	Trust in building therapeutic alliance Not making false promises Building trust Being honest	<ul style="list-style-type: none"> <li>• There have been all kinds of feelings in the relationship but I think ultimately moving towards something more kind of trusting.</li> <li>• To come and have a trusting relationship as what's happened to them has happened in relationships. The relationship is a vehicle for change.</li> <li>• At least you are giving the person some hope that something will be done about it and a trust will be built up as long as you go and do it.</li> <li>• I think it's important for trust to be built with a clinician who can understand their difficulties.</li> <li>• Building trust is important but this takes a long time because trust is of course one of the problems.</li> <li>• It might take some time for them to come to know and trust the staff in here and also to relate to staff in here.</li> </ul>
	Need for consistency	<b>HELPFUL:</b> Need for agreement Sense of consistency Shared care planning Shared information enabling consistency Shared philosophy amongst team Value of maintaining a consistent approach	<ul style="list-style-type: none"> <li>• Having somebody who the client really, really knows well and who the client trusts to kind of engage with them during a period of crisis is incredibly helpful.</li> <li>• Just being someone who was there at the same time every week who was consistent who was relating to her in a very different way from all of these other relationships in her life.</li> <li>• Consistency, availability, consistent philosophy, background philosophy that the team holds in common.</li> <li>• Trying to optimise the consistency and functionality of the response that we give to people.</li> </ul>

		<ul style="list-style-type: none"> <li>• Rather than have her ending up in hospital we used the crisis team and again the psychiatrist she had seen was the psychiatrist in the crisis team so there was that continuity and they were very proactive with her and then discharged her back.</li> <li>• To have a care plan that says when I am next in this emotional state and engaged in these types of behaviours this is how I want the service to respond.</li> </ul>
	<p>UNHELPFUL:</p> <p>Unhelpful if inconsistent messages given by clinicians</p> <p>Intermittent inconsistent responses reinforcing dysfunctional behaviours</p> <p>Varying opinions unhelpful</p> <p>Not useful if services are inconsistent or irregular</p> <p>Unpredictability unhelpful</p> <p>Erratic services</p> <p>Contradictory or mixed messages not helpful</p> <p>Staff changes too often</p> <p>Lack of continuity of care</p>	<ul style="list-style-type: none"> <li>• I've so often come across situations where I'm trying to say something, the psychiatrist is saying something different, the nurses are saying something different and the social worker is saying something different and for somebody who is really chaotic at any point in time you know having mixed messages about what might be helpful and what they should do isn't helpful at all and it just makes the situation worse.</li> <li>• Putting more time and effort into building a kind of therapeutic relationship and looking after it and nurturing it which takes time.</li> <li>• I'm really opposed to this quickly moving from team to team and person to person approach. Passing people around isn't actually going to build up a relationship and that is a key element in holding the process.</li> <li>• I wish services had the resources to work in the longer term really and that their work could be more consistent.</li> <li>• Quite a lot of people referred will be seeing half a dozen people, their CPN, psychiatrist, priest etc and they come back with different responses from each of them and this is not helpful.</li> <li>• Because they [inpatient ward staff] are working shifts the staff are never together at one time it becomes difficult to build consistent responses.</li> <li>• I think its consistency and we often don't provide that because in an emergency someone can phone up here, they can go to the crisis</li> </ul>

		<p>team, they can turn up at the emergency department, they can go to their GP and everywhere they go they will get slightly different advice.</p> <ul style="list-style-type: none"> <li>• Certain responses [from services] reinforce dysfunctional behaviours and if those responses are given intermittently then that's a powerful reinforcer of behaviour, especially when a system gives a consistently inconsistent response.</li> <li>• Engaging in eclectic miss-mash therapy is not helpful.. You need something to hold onto because eclecticism just goes all over the place.</li> </ul>
	<p>Boundaried &amp; challenging clinicians</p> <p>Setting limits Safety through boundaries Sticking to boundaries Sense of setting appropriate boundaries Limits placed to identify power difference Being more authoritative Being fixed and firm Being rigid and structured Sense of not becoming overly-friendly with service-users</p>	<ul style="list-style-type: none"> <li>• There were lots of boundary issues and being able to notice and respond to them was really important in terms of providing a sense of containment.</li> <li>• Making sure there are boundaries and that I am clear what they are.</li> <li>• We need many more boundaries in our therapeutic relationships with people with a BPD.</li> <li>• You've got to be very careful about boundaries as this woman has got into dysfunctional relationships with therapists in the past.</li> <li>• I was very proud to see her describe me as being rigid because that is exactly how I wanted to come across.</li> <li>• I think she experienced me as difficult or serious perhaps when she perhaps wanted to invite me into something much more jokey.</li> <li>• It's the unit that provides a boundary for these people and if you take away the unit then they fall to pieces. If you take away their boundaries then there will be a major suicide attempt or they will get involved in drugs and alcohol again.</li> <li>• I find myself being more formal with people with BPD rather than with people who might have other types of mental illness.</li> </ul>

<b>Acceptance and validation</b>	Sense of belonging	<p>Support provided through others</p> <p>Valuing friendships with other service-users</p> <p>Sharing similar experiences</p> <p>Finding safety with others with similar difficulties</p> <p>Safety being with other service users</p> <p>Group experience</p> <p>Community feeling</p>	<ul style="list-style-type: none"> <li>• They have met up with people on the ward during their admissions and struck up friendships and developed something supportive there.</li> <li>• To work through some of their issues with people who have had similar experiences.</li> <li>• It is very useful for people to feel a part of something when often they are alienated from friends, family and they often don't have any substantial relationships outside.</li> <li>• They meet people who know much more about their experience than we ever will.</li> <li>• The whole living experience is where the power is really. The social life and times together, eating together, the cooking together.</li> <li>• People come in here, sometimes accompanied off of the wards, because we take on everybody here.</li> <li>• The philosophy behind groups is it is like a microcosm of the outside world and that she would learn from those difficulties in the group to help her in the future.</li> <li>• there's an enormous benefit to working as a as a mini-society, a micro-society even in groups... we are in a large part social creatures and we need each other even though we deny that need but we do need each other... Not just for safety but for emotional security and for love.</li> </ul>
	listening and understanding	<p>Developing empathy</p> <p>Understanding about BPD</p> <p>Learning how to respond to people with this diagnosis</p> <p>Being understanding</p> <p>Listening to people</p> <p>Understanding difficult or challenging behaviours</p>	<ul style="list-style-type: none"> <li>• I understand a lot more about the origins or the early experiences that often lead to these problems so I suppose they still are a challenge to me a lot of the time but I think I am much more sympathetic now.</li> <li>• Enabling people to think about how they respond to projections, splitting, and how they can develop empathy with people with PD and how they can sit down and really listen to where their crisis is and help them through it. That would be helpful that basic sort of learning.</li> </ul>

			<ul style="list-style-type: none"> <li>• You would check out what's gone wrong and you try to see their point of view</li> <li>• We did not reject [discharge] the patient at this point and we tried to understand what was going on [talking about a fight in the group]</li> <li>• We've tolerated a few angry outbursts, throwing cups, charging out, she was suspended for a week but came back and we tried to understand things from her point of view.</li> </ul>
<b>Risk and responsibility</b>	Shared risk management helpful	Shared responsibility Support in risk taking Team approach to risk management Sense of thinking together about risk Being part of a team decision to risk Working collaboratively Unified risk management Managing risk as a team Sense that shared risk management reduces clinician anxiety	<ul style="list-style-type: none"> <li>• You are never kind of on your own left thinking about a patient which has felt very supportive having a shared thinking space.</li> <li>• I have also learnt about the importance of a team approach in working with risk.</li> <li>• It's more anxiety provoking at times where you feel that you are managing risks by yourself.</li> <li>• It's trying to think together about why this person has taken an overdose.</li> <li>• I think things can go badly wrong if there's not a shared understanding of what the risks are.</li> <li>• People are on board with the model and that way of thinking so you can share the risk and share the way of thinking about people.</li> <li>• The team is extremely good at saying we will share this decision, we will share this problem so that is how we defuse it.</li> <li>• Having team members sharing a unified view and willing to as a team accept the risk of that position is helpful.</li> <li>• Teams that don't panic under pressure and don't start fire fighting, teams that can actually think in a non-rejecting way about what might be helpful.</li> </ul>
	Positive risk taking	Taking positive risks Not over-reacting Sense of needing to try and reduce	<ul style="list-style-type: none"> <li>• Taking the risk that most of them won't kill themselves and the vast majority won't do it.</li> <li>• My philosophy was to under-react rather than getting very anxious</li> </ul>

	<p>anxieties in clinicians                      Not reinforcing behaviours with more attention from services                      Not placing people in hospital unnecessarily                      Discharging people earlier                      Knowledge that people will not harm themselves</p>	<p>and reacting.</p> <ul style="list-style-type: none"> <li>• Working with staff teams on the wards and community teams to encourage them to discharge the patient as soon as the crisis has settled to not keep them in hospital observing them and encouraging them to take positive risks with a backup plan.</li> <li>• Sometimes I have to take those positive risks and not react at all.</li> <li>• Don't inadvertently reinforce damaging or dysfunctional behaviours by only giving attention to someone when they cut themselves. It isn't necessarily going to reduce the frequency of cutting.</li> <li>• Crises that tends to prompt her appearance with services and there's always high drama, high threats of suicide although very little acting on that and people around her get very anxious and this is not helpful.</li> </ul>
Shared team understanding	<p>Team discussions                      Sense of working together                      Working collaboratively in teams                      Sense of needing to consider together how clients effect the team                      Having a shared thinking space                      Sharing thoughts about clients                      Considering difficult emotions within the team                      Multiple professionals working together                      Helping each other with complex issues                      Unified view                      Collective experience of sharing issues</p>	<ul style="list-style-type: none"> <li>• I don't think we actually sit and think through what impact they are having on us as a team or individuals and what our reactions are.</li> <li>• Services need spaces where they can do thinking together about the impact on them of working with personality disorders.</li> <li>• It is important to have a team working very closely together so there is no splitting and so we can explore between us what approach we are going to adopt and explore anything that arises within the team emotionally.</li> <li>• We are constantly thinking together.</li> <li>• People having a psychological formulation and to be able to hold that in a team of people or in relation to understanding somebody's difficulties.</li> <li>• It's looking at a multi-professional approach at working with people who are challenging because I think that's where a lot of the negative stuff comes from if you are working with somebody on your own.</li> <li>• Agree with the inpatient team that she would have a written contract, a passport, a written letter signed by me and the inpatient consultant saying that she can have a 48 hour admission on request.</li> </ul>

		<ul style="list-style-type: none"> <li>• If you are working with a team that everybody is doing the same thing and giving the same message to the client then that is helpful.</li> <li>• Having a named model that everybody is on board with. Everybody does the same model, supervision groups the team working together is all within the same model</li> <li>• The way we are configured with multiple locations in which people can access our services in emergencies means it's very hard to maintain a consistent response to people who are in crisis.</li> </ul>
Responsibility given to the client	<p>Need for clients to become more responsible</p> <p>Clients responsibility for behaviours</p> <p>Sense of being clear about clinicians roles and clients responsibilities</p> <p>Clients accountability</p>	<ul style="list-style-type: none"> <li>• Making it clear where my responsibilities lie but where their responsibilities lie too and that I am not responsible. I can't protect them you know my role is not to keep them safe 24 hours a day.</li> <li>• We try and give responsibility and power to them which you can do in a group situation.</li> <li>• She [client] was trying to make me anxious and for me to take responsibility for her behaviour but I wasn't going to do that. She needed to become more responsible for her behaviour.</li> <li>• I wish that people on the wards were being required to do some thinking and take some responsibility for their behaviours rather than just stepping into the obis but it's worse than the obis actually because its retrograding...I think they should be required on the wards to sit down with the others and think about what's gone wrong.</li> <li>• [talking about the client having a treatment plan] She doesn't necessarily ring up and terrorise the staff by threatening to kill herself. She can now ring up and just say that she needs time out.</li> <li>• I didn't impose this care plan on this woman when I agreed it with her and she co-signed it. This was the deal and I think this is the approach that we need to take with people otherwise we become part of the problem.</li> <li>• Her knowing that she wasn't being forced or trapped into something. She was opening up those areas of discussion on her own terms...</li> </ul>

			<p>that's important that she is in charge of these things.</p> <ul style="list-style-type: none"> <li>• She felt very much that it was her care coordinator's idea and that actually it wasn't the right thing for her.</li> </ul>
<b>Invalidation and rejection</b>	Difficulties being discharged	<p>Discharge and rejection</p> <p>Self-harming to prevent discharge</p> <p>Services trying to get rid of people</p> <p>Rejecting services</p> <p>Abandoning people</p>	<ul style="list-style-type: none"> <li>• The trouble is that I knew it would happen in that she has attached herself to me and so her diary that she keeps is now full of you know what will happen when my [clinician] rejects me like everybody else.</li> <li>• Their experience of the discharge from the ward is felt as a big rejection. The time of discharge seems to be quite arbitrarily decided but actually the ward or the whole system has had enough of working with this person.</li> <li>• She would also take overdoses while on the ward so that for months they felt they could not discharge her.</li> <li>• every time I tried to talk about that ending she would lay into me and say you're trying to get rid of me, you've given up on me and refusing to think of the ending happening. A lot of our work was damaged in that final session because I avoided this because of her anger at ending</li> <li>• I think she felt abandoned by me when I discharged her.</li> </ul>
	Exclusion and abandonment from services	<p>Sense of being excluding</p> <p>System being un-empathic</p> <p>Belief that this diagnosis is untreatable still exists</p> <p>Invalidating</p> <p>Abusive</p> <p>Being rejected or abandoned</p> <p>Feeling of isolation</p> <p>Sense of not being liked by others</p>	<ul style="list-style-type: none"> <li>• What is really unhelpful is services that are rejecting and are trying to get rid of people that are difficult to work with.</li> <li>• I'm reluctant to use this as I don't want it to be a label that people will use to exclude people yet all the time we collude with this it will not change will it?</li> <li>• When people start getting pushed away or rejected and labelled and whatever else it's really not helpful</li> <li>• What you get is a lot of clinicians pushing people away and kind of reinforcing what this person is struggling with in the first place. It's feelings of being unheard, rejected, etc.</li> <li>• The system has not been until recently at all empathic towards them.</li> </ul>



		<ul style="list-style-type: none"> <li>• They are going to be vulnerable to rejection because of the way that they relate to people on the ward.</li> <li>• On the wards they are very busy and the staff haven't got the time to really work with somebody psychologically</li> <li>• She felt that I was being kind of headmistress... so she felt very told off and criticised.</li> </ul>
Sense that services judge people with BPD	People being pathologised Insulting labelling used Label described as blaming Pejorative label	<ul style="list-style-type: none"> <li>• People can be so misunderstood or pathologised really.</li> <li>• The phrase PD is often used as an insult for people.</li> <li>• It's quite easy to blame clients as I think you do still hear that quite often.</li> <li>• Clinicians that don't agree or can't agree whether personality disorder is a mental health problem or not is very unhelpful.</li> <li>• Just because this person is very demanding or assertive they are given this label.</li> <li>• PD is such a taboo label it's so pejorative yet other things have become so much more acceptable.</li> <li>• When somebody has been around in services for a long time and they develop a reputation amongst clinicians and often not in a nice way.</li> </ul>
Services lacking understanding		<ul style="list-style-type: none"> <li>• They [ward staff] don't think they [people with BPD] are ill in the sense that psychotic patients are ill so they keep re-experiencing the past traumas if you like of rejection, antagonism, and so forth with people who are so called parental figures</li> <li>• [psychiatric] nursing staff will tell them they don't have a real mental illness, it's not a mental illness.</li> <li>• It doesn't help them [people with BPD] to get admitted because the staff they basically don't like them. They don't have a good understanding of BPD.</li> </ul>
<b>Dependency</b>	Sense of wanting to be cared for by	<ul style="list-style-type: none"> <li>• They take an overdose due to some crisis in a relationship, some rejection or something and present to A&amp;E and get admitted to</li> </ul>

	services		<p>hospital, quite like it in hospital but at the same time resent it, go out, do the whole thing over and over again and they keep presenting with self-harm of one sort or another.</p> <ul style="list-style-type: none"> <li>• Consultants in charge of the wards are not going to release people if they are going to kill themselves and the people are going to keep saying I'm going to kill myself if you let me out so it's a real double-bind.</li> <li>• every time they attempt to discharge her she goes and sits on the bridge and the police pick her up and she goes back in again and well she's going to become a chronic patient because then they observe her on the ward and prevent her from going out and then they try to discharge her and the same thing happens again.</li> <li>• She had repeated admissions to hospital with small overdoses or terrifying junior doctors at 3am that she was going to go home and take a massive overdose so she got admitted several times.</li> <li>• They create relationships of longing for something that is safe and secure like the womb, like the ward, you know you hear people say the feeling when you when you get seen by the psychiatrist on the ward and the nurse comes and they take you in and show you in a room is just wonderful.</li> <li>• Wanting to be part of the care system and wanting to be dependent on it... not about wanting to get better.</li> </ul>
	Services to blame for over-dependency	<p>Unhealthy relationships formed Dysfunctional issues Iatrogenic effects of services Re-traumatising people The system being the problem Needing to treat the service to treat the individual</p>	<ul style="list-style-type: none"> <li>• We need to behave more healthily to help people with Borderline behave more healthily. Our whole system is set up to allow that type of dysfunctional interaction with services.</li> <li>• I believe that I'm not just treating her, I'm treating the sick service that we have. She thrives on chaotic responses from services and I think this also feeds into her chaos.</li> <li>• Contact with services have not always been very helpful and has contributed to their difficulties.</li> </ul>

			<ul style="list-style-type: none"> <li>• We have dysfunction interactions with people with a borderline personality disorder and a lot of that is focussed around an agenda to give medication.</li> <li>• All the same problems that happen in the persons childhood about being not really related to properly happen again and the relationship breaks down and they all run away.</li> <li>• Some people get re-traumatised in services</li> <li>• Maybe she has tried many times but has collapsed back into it and then become addicted to the system and the drugs.</li> <li>• They have been treated as revolving door patients who have spent years in hospital and now you can't be years in hospital anyway so now people are thinking how else can they be helped?</li> <li>• The service encourages people to be dependant. Instead of teaching people how to solve their problems someone will solve their problems for them.</li> <li>• if you have a service that is slightly more cold and dispassionate when she presents in a crisis I think that might actually communicate itself to her</li> <li>• I always think that somebody wouldn't have to repeat something again and again if they weren't trying to tell you something. You know, there's no point in going over something again and again or acting out in a certain way again and again if the other person picks up whatever it is you're distressed with. I find it very unhelpful when clinicians can't think about that or the meaning of the behaviour.</li> <li>• Maybe you have made somebody dependent but it needs to take responsibility for that. You know if you contributed to an over-dependence then you need to contribute to somebody being able to let go of the service rather than rejecting them.</li> </ul>
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Symptom management			
	Medication unhelpful	Theme around un-treatability through medication Unhelpful to give medication for BPD Over-medicating Being given a cocktail of drugs Becoming addicted to medications Sense of people being drugged up	<ul style="list-style-type: none"> <li>• You can't treat the core features of BPD with medication and the only justifiable use of medication is to treat co morbid conditions.</li> <li>• Like most doctors my need to do something makes me reach for my prescription pad because you do feel better if you have written a prescription and even though at the back of your mind you know it's not going to help.</li> <li>• I think a lot of the patients are over-medicated... NICE guidelines recommend that they are not medicated.</li> <li>• She was just given loads of pills which never made any difference</li> <li>• She was on quite a cocktail of drugs for quite a long time and I'm not really sure why.</li> <li>• Over the years psychiatrists have tried to manage people's interpersonal problems by sedating them.</li> <li>• People now think medication isn't the answer and in a way that makes it even more of a case for psychological treatment</li> <li>• If you start off by not medicating then there's probably more chance of enabling the person to contain their feelings psychologically but I think once they have been on medication for a long time I think it's a lot harder to get them off of it.</li> <li>• I rather suspect that for every pill you prescribe you would be stopping four or five with the idea being firstly to prevent the damaging effects of over-prescription but secondly to see whether there is a co-morbid mental disorder that might benefit from medication.</li> </ul>
	Patching up symptoms	Managing symptoms Sense of not getting to the root of problems Symptom relief Behavioural rather than	<ul style="list-style-type: none"> <li>• Short term interventions, some things like CBT have a place here in terms of just managing symptoms but not in any way that I would see it as treating people but certainly manage people, supporting people to not be so disturbed and I think that is a valuable thing in itself really.</li> </ul>

		<p>emotional/ relational Short-term outlook Not looking at longer-term gains Needing to work quickly with people Aim of moving people on quickly</p>	<ul style="list-style-type: none"> <li>• Someone has listened and supported them and understood their mood for 10 weeks or 20 weeks but only acts like symptom relief... they really haven't changed the way in which they deal with the world.</li> <li>• There is still quite a medical model of "you're ill so you're coming in to be treated and you're going to be leaving again when you're well" ...this isn't going to fit for people with this cluster of problems.</li> <li>•</li> <li>• It is almost crisis management. The very thing that we are supposed to not be doing in psychotherapy is what we are turning into.</li> <li>• Working with the cognitive mind rather than the feeling mind is another form of symptom control.</li> <li>• We need to look for change that goes deep, not just change in behaviour.</li> <li>• They are sort of patched up during a period of crisis and then when they are in their next crisis they come back.</li> <li>• People might have been encouraged to change parts of their behaviour but only so that it comes out somewhere else. If you stop someone cutting they usually get an eating disorder. These are all symbolic behaviours. They have meaning.</li> <li>• [CBT] is no good for this group because it doesn't allow for their emotions, it doesn't look at their emotional life and everything that's wrong is about their emotional life</li> <li>• We work with people for shorter periods of time so it does not really address what is really going on. You know, what the origins really are.</li> <li>• What they are doing is managing her and I think partly that's because I don't think that person really wants to be different.</li> <li>• I don't have a lot of time for cognitive approaches and brief therapies just because there's a requirement to do things as quickly</li> </ul>
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			as possible. <ul style="list-style-type: none"> <li>• You have to be working towards some point where you are going to be able to challenge but to do that in 20 sessions is impossible.</li> <li>• I think they have to understand and get rid of the ridiculous constraints about time. They have this fantasy about what treatment is and it does not bear any resemblance to treatment.</li> <li>• Getting to know people rather than just going for the problem but that takes time.</li> </ul>
<b>Dis-empowerment</b>	Ward environment and feeling abusive	Trauma of ward environment Re-traumatising experiences Re-experiencing traumas Abuse on the wards Harmful to be on the wards Not feeling safe on the wards	<ul style="list-style-type: none"> <li>• The way that they [people with BPD] relate to authority will make them vulnerable to over-coercive methods by staff as well as being exploited by the patients [on psychiatric wards].</li> <li>• The next day you wake up in the ward and it's not so wonderful so they set themselves in an adversarial way and start repeating a relationship that they had at home or something and it just gets more and more entrenched.</li> <li>• There are terrible things that have happened whilst she has been in hospital which confirm my view that the acute wards aren't good for her.</li> <li>• For somebody who is really broken down the ward is really helpful but it needs to be a kind, empathic kind of stay in hospital and this is very rare.</li> </ul>
	Empowerment through diagnosis sharing	Need to provide diagnosis Helps clients understand difficulties Sense of diagnosis information being useful Exploring diagnosis with clients Normalising difficulties	<ul style="list-style-type: none"> <li>• Some people do genuinely appreciate the idea of diagnosis to this condition because it makes them feel they are not unique in that there are other people that there are a recognised set of problems</li> <li>• One of the problems is that people quite often don't get that formal diagnosis.</li> <li>• One of the things that helped was to have a frank discussion about a label such as BPD.</li> <li>• She looked at some of the literature about BPD and read some of the</li> </ul>

			<p>symptoms and she really recognised that but it was also put in a way that helped her understand.</p> <ul style="list-style-type: none"><li>• You’d want a care plan that was communicated and ensured rapid access to the type of psychotherapy that might hold, contain and help the person</li></ul>
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**Appendix 15: Categories, sub-categories, open codes and example quotes for service user participants**

Category	Sub-category	Open codes	Example quotes
<b>Secure attachment relationship</b>	Clinicians as safe parental figures	Father figure Mother figure Parental figure Feeling attachment to clinician Looking for parental / father or mother figure in clinicians Feeling secure Feeling safe to explore problems Feeling nurtured Feeling cared for Sense of being looked after Sense of clinician as holding power and providing safety	<ul style="list-style-type: none"> <li>• He was a very good father figure role as well and I think I got very attached to him as a positive figure and I guess in that kind of man.</li> <li>• She was a kind of mother figure and that's what I felt I had at that moment in time and I've always longed for that care.</li> <li>• Wrongly or rightly I see them as the parent figures because I've never really had the parent figures myself.</li> <li>• I've longed for that emotional attachment and I do look at the therapists as parents.</li> <li>• [Talking about a therapist who had recently left the service] it was like losing the mum I never had. I had grown very attached to her.</li> <li>• It's like having my dad here because my dad is very similar to how he is as a therapist.</li> <li>• I feel very safe with [therapist]. I feel very comfortable with [therapist]. He's a very gentle person and he talks very gently and I think I find that quite soothing and non-threatening and it brings out the best in me.</li> <li>• I felt safe because he was really caring and dedicated and he spent a lot of time with me.</li> </ul>
	Establishing trusting relationships	Trust built over time Trust through building relationship Having faith or confidence in the clinician Keeping confidentiality The importance of truth Honest/y in services Unhelpful if dishonest or make false promises	<ul style="list-style-type: none"> <li>• He [therapist] was just really honest and up front.</li> <li>• Given the chance to open up, trust people and given the time that you need to open up and I've shared things in this community that I thought I would never share. It's the trust that's important.</li> <li>• He's been there every step of the way so I have opened up to him.</li> <li>• You can't expect them to know everything because they are not magicians with wand's and stuff so I need to tell them stuff. I see it as a safety net really. I feel OK telling them stuff.</li> <li>• When you trust that person you feel you can talk to that person a lot</li> </ul>



	<p>False promises reducing trust</p> <p>Importance of being realistic</p> <p>Being let down and losing trust in others</p>	<p>more easily and a lot more comfortable.</p> <ul style="list-style-type: none"> <li>• She keeps things confidential so I can trust her.</li> <li>• I felt as if I could trust him and he had trust in me.</li> <li>• we've built up trust and people can come up to me now, they can cuddle me and can make eye contact and I find I feel comfortable.</li> <li>• When you question someone and they say "oh no I never did that" then you are bound to feel that you lose respect or trust.</li> <li>• It's when you're told lies it's unhelpful.</li> <li>• It was because she raised my expectations. She said I'll meet you at a certain time so I went to the office and she wasn't there and that happened more than once so the disappointment was building up.</li> <li>• She was trying to make me feel better and safe but don't do that unless you follow through.</li> <li>• I saw a psychologist there but she let me down so. She said she had to tell the staff that I was drinking when I went home so that's not confidentiality really.</li> <li>• I never know whether to trust them and they don't know whether to trust me. It works both ways.</li> </ul>
Need for consistency	<p>Helpful:</p> <p>Remaining the same</p> <p>Adhering to same principles over time</p> <p>Behaving the same with other service-users</p> <p>Consistent approach helpful</p> <p>Security through consistency</p>	<ul style="list-style-type: none"> <li>• It makes a huge difference when you see someone who is really good and is consistent over time. You know what you can expect from that person.</li> <li>• She [helpful nurse] got everything done because she was always the same. She never treated anybody differently and she got her job done.</li> <li>• If they are not available when you call then they will always ring you back, they never don't so you know what to expect.</li> <li>• He [psychiatrist] would actually be consistent with that person, stay with that person and work with that person together.</li> <li>• They communicate well from the word go, they stay with it and are consistent. They also make it very clear their approach to you.</li> </ul>

		<ul style="list-style-type: none"> <li>• It's quite important that if you have a programme you do sort of stick with the same person that has obviously known you and can work with you.</li> <li>• She's very helpful and she's been around in my life for a number of years.</li> <li>• So it's good as I had [therapist] in my outreach so it's a familiar face from here [TC] and then others from your outreach group also come here [TC] so there's more familiar faces.</li> </ul>
	<p>Unhelpful:  Varying opinions unhelpful  Not useful if services are inconsistent or irregular  Unpredictability unhelpful  Erratic services  Contradictory or mixed messages not helpful  Staff changes too often  Lack of continuity of care</p>	<ul style="list-style-type: none"> <li>• You do get a lot of different opinions off a lot of people from the same profession. It's very confusing.</li> <li>• My recent dealings with psychiatry has been very intermittent and not regular basis and not with a regular person</li> <li>• Different doctors would say different things.</li> <li>• The psychologist usually changed and that's not been very good. You get used to one and then they change to someone else.</li> <li>• It [appointment with psychiatrist] was just once every 6 weeks unless they cancelled so it was hard to build up trust.</li> <li>• I couldn't understand if I was coming to see a therapist and I was doing treatment then so why would I go and see a psychiatrist.</li> <li>• Every time you see a new psychiatrist, there was no continuity and I never actually knew who I was seeing.</li> <li>• You see somebody [clinician] and they refer to somebody else and then this persons forgotten something or they get your name wrong or your file mixed up and you end up thinking who did I see and what for?</li> <li>• Well my psychiatrists changed so often that I never had that permanent person there that you could actually begin to trust. By the time you might have built up some kind of relationship with them, off they went so I kept everything bottled up.</li> <li>• When you see a psychiatrist you're given 10 or 15 minutes, you're</li> </ul>

		out the door that's it and then every 6 months they change anyway so you don't build up that relationship.
Boundaries setting and challenging	<p>Setting limits                      Safety through boundaries                      Sticking to boundaries                      Sense of setting appropriate boundaries                      Limits placed to identify power difference                      Authoritative                      Being fixed and firm                      Tough clinicians helpful                      Therapists needing to be strong enough to challenge                      Not just being nice clinicians                      Stick with difficult feelings</p>	<ul style="list-style-type: none"> <li>• They have strong boundaries and they explain those boundaries so I feel safe enough here.</li> <li>• All through my childhood I never had boundaries put in place so yes boundaries are good as I was suspended for it [throwing cup at someone] but I was able to think about its effect of the community.</li> <li>• She [nurse] cared by not putting her arm around you and loving you but she cared by doing her job properly, being boundaried, and providing the care that she was there to provide. You can have a hard-nosed person that I don't mind but if they have that then you will feel safe and cared for.</li> <li>• Therapists are like the authority but I feel safe with this.</li> <li>• I really like my psychiatrist, I think she's great but she scares me. Not in a nasty way but she's very authoritative, strict, so I know where I stand.</li> <li>• [Therapist] will challenge you but he is also very supportive.</li> <li>• She [therapist] wouldn't force me but she wouldn't let it lie. You know, she'd make me stick with the feelings.</li> <li>• The fact that I was angry with him was because I knew he was right. Sometimes knowing that someone is right makes you really, really angry but it helped me to see where I was going wrong and it felt OK as he could cope with me being angry with him.</li> <li>• She [therapist] was very forwards, not aggressive, up front, she didn't beat around the bush.</li> <li>• She's hard work but true in what she says. I wouldn't thank you for a therapist that pussy-footed around now so I like the tough but when you're in it you don't want it.</li> </ul>

			<ul style="list-style-type: none"> <li>• She [therapist] was lovely, really nice but she was too soft. She was too soft. I need to be challenged.</li> </ul>
<b>Acceptance and validation</b>	Sense of belonging	Shared purpose Feeling welcome Family atmosphere Sense of being like a home Being recognised Shared understanding Feeling a part of something Community feel Membership Group involvement Safety with others of similar difficulties Feel more comfortable around others with similar problems Feel less isolated Understanding as share same difficulties Fitting in Support each other Contact out of therapy is helpful Being there Gaining help from other service-users	<ul style="list-style-type: none"> <li>• It feels a bit like a family, especially in [Hospital]. We'd watch TV, eat together, listen to music together and if we wanted a bit of space then you had your own cubicle area.</li> <li>• This is some kind of home and I say it all the time, I've got my belongings in my room and I consider it my home and I make it feel like home in here. I've got a nice, warm quite and dry room and it feels like it's mine.</li> <li>• It was more friendly from the word go. I can't emphasise how everybody has a role to play.</li> <li>• The resource centre is awfully good. It's a really nice atmosphere there.</li> <li>• Friendships are beneficial here especially for people who find it hard to form relationships.</li> <li>• The receptionists are friendly, they'd recognise you after a period of time, you're made to feel welcome.</li> <li>• I mean you get attached to the members and everyone.</li> <li>• We understand, a lot of us are self-harmers so we can understand a lot of where we are coming from really and can respect each other.</li> <li>• Being in a group where other people have the same personality disorder means you don't feel so alone, you can share things and it's not just you like this.</li> <li>• [Talking about what is helpful] Being in a group therapy session where everybody has similarities, i.e. we've all got BPD.</li> <li>• I've made a lot of friends here as we've got similar problems.</li> <li>• It's the fact that you can be around people who have got similar</li> </ul>

		Learning from others	<p>minds and ways of thinking.</p> <ul style="list-style-type: none"> <li>• I've known a lot of the other people for years and years and they are all quite pleasant together.</li> <li>• We're always on the other end of a phone for support.</li> <li>• It's not only the therapists but the group as a whole. We're very supportive of each other.</li> <li>• In a small group you get to know those people a bit more and you're listened to a bit better and you can say things. They are more supportive really.</li> <li>• I get along with them. They're supportive and they involve themselves with you. They join in with whatever you're doing.</li> </ul>
	Being listened to and understood	<p>Actively listened to Being heard Being understood Being given time to talk Given attention Accurate reflection Being asked questions Clinicians want to find out more</p>	<ul style="list-style-type: none"> <li>• He [psychiatrist] helped me understand how I felt about my sexuality. He actually listened.</li> <li>• Even just the GP being just a little bit more sort of trying to listen.</li> <li>• Being able to talk and being given the chance to talk and given the time.</li> <li>• He talks to you and asks how you're feeling.</li> <li>• Actually understanding you on another level which is personal perhaps or wanting to know about your past.</li> <li>• [Talking about the psychologist] It's like having a chat and having somebody listen to you about your troubles. Trying to see some sense in your own behaviour that you find upsetting.</li> <li>• I knew she really did love the job and she really did care about the people she was trying to help because she took the time to listen.</li> <li>• I think that empathy of somebody actually understanding. That was quite true in a way because a few years later I saw him at a gay bar.</li> </ul>
	Belief and respect in the individual	<p>Belief in the individual Respectful Feeling valued Interest shown in the person</p>	<ul style="list-style-type: none"> <li>• They genuinely seemed to find the best in me. They complimented me on how I was doing and listened to me.</li> <li>• I think he believed in me. I think he really believed in me and he actually said I was a pleasure to work with. C</li> </ul>

		Feeling equal to the other Sense of being valued	<ul style="list-style-type: none"> <li>• I felt I could talk to him, say how angry I was and I'd got angry with him but I was able to voice that and he understood and didn't reject me. I felt accepted.</li> <li>• He remembers things, he remembers things I said 3 weeks ago which I think is great.</li> </ul>
<b>Invalidation and rejection</b>	Difficulties being discharged	Fear not able to cope without services Sadness at being discharged Feel abandoned when discharged Sense of being discharged and rejected Feeling alone when discharged Fear of becoming too attached	<ul style="list-style-type: none"> <li>• I said I was OK [being discharged] but then I just burst into tears. I felt I was being left on my own.</li> <li>• You can't just leave me now you know [therapy ending]. I need you to help me make sense of all this.</li> <li>• It is going be difficult to leave and go from 3 days a week to 2 hours a week because I have built up such an attachment to everybody here.</li> <li>• I do worry that if I crash, if things get on top and I don't sort of continue what we've learnt here with having support here.</li> <li>• It's [being discharged] feeling nervous about going back to where I was without the support I have here.</li> <li>• You [services] don't just come in when you [services] feel like it and then go bye-bye.</li> <li>• A&amp;E have got no compassion for you whatsoever. They just wanted me out as they didn't know what to do with me anymore.</li> </ul>
	Exclusion and abandonment from services	Feeling excluded by services Being left Feel rejected if no response from services Feeling abandoned Feeling uncared for No phone calls returned Services refusing to see	<ul style="list-style-type: none"> <li>• I wanted therapy and he refused to see me.</li> <li>• The duty team were unhelpful because they never got back to me. They never seemed to want to help me.</li> <li>• I felt so alone because no one wanted to help me.</li> <li>• When I've gone back into hospital again and I have just been left there, dumped.</li> <li>• They [staff] don't seem to give up as much with others. They give up more with me.</li> <li>• When he [doctor] went [left the service] I felt as if I'd just been</li> </ul>

	<p>people Staff not talking to people Uncaring/unsympathetic Denying therapy Sense of being discarded Not accepted</p>	<p>dumped, like what my family have done, so called friends have done, so I thought the system itself was letting me down.</p> <ul style="list-style-type: none"> <li>• I was really hurt by her comments and then I kept it to myself and a few weeks have gone by and I've watched her in art therapy with other people and she is totally different.</li> <li>• They say they will phone you back but they won't because they are busy so you have to really cope the best way you can.</li> <li>• They sectioned me and I was just dumped in the hospital for the first time. I was heavily pregnant with my little boy and I just deteriorated so they threw me in there and left me. I'll never forgive them, never.</li> <li>• It was my 35<sup>th</sup> birthday when I was on the ward and they didn't even celebrate, no card, no cake, no anything. I was in tears, I thought surely I can't be that bad a person that the birthday isn't celebrated. They didn't want to know, they didn't care.</li> <li>• It's the worst thing that's been done to me being put in the seclusion room. I'd rather have people's company</li> </ul>
<p>Sense of feeling judged and misunderstood</p>	<p>Stigmatised judgemental response Blamed by others Criticised Sense of being looked down on Sense of forming an opinion without knowing the person Being discriminated against Socially disapproved of Feeling labelled Pejorative labelling Sense of being devalued Feeling mocked or teased</p>	<ul style="list-style-type: none"> <li>• There is still the stigma attached to it [BPD] and people don't want to understand it and it's just the lack of understanding of it all round really.</li> <li>• I found he, to be honest, I felt he judged me.</li> <li>• One of the things that was said to me very early on and is said to other people is you're bound to find fault because that's part of your disorder, you're bound to criticise or question because that's part of your personality disorder... that negates their responsibility if they do anything human, wrong, or whatever.</li> <li>• People can find that they can get called labels for illnesses and stereotyping and it can be quite scary.</li> <li>• There was no understanding or caring side [on wards]. They were almost like saying sort yourself out, stop being stupid, stop being</li> </ul>

	<p>Not understanding Diminishing someone's feelings lacking compassion through not understanding Labelled as misbehaviour/ing</p>	<p>silly.</p> <ul style="list-style-type: none"> <li>• They used to say that basically I was being silly and I'm not, you know, there's no problems and you need to pull yourself together and that I found the very least helpful.</li> <li>• I was finding it [ward] was bringing me back down again... they don't take you seriously.</li> <li>• Nearly every member of staff I've seen is miserable and they don't want to be there so they don't engage with you as a human being.</li> <li>• Someone said to me in hospital once it was an NA [Nursing Assistant] who said, "the only reason you self-harm is so as you can get into hospital".</li> <li>• [Talking about hospital] She has a go at me so I have a go back. We get in an argument and she sticks her nose into things and she starts it. She always has a go at me.</li> </ul>
Sense of being ignored	<p>Not listening Not hearing the individual A sense of being ignored Sense of not being heard Lack of Not being noticed Lack of acknowledgment Disregarding Neglecting the person</p>	<ul style="list-style-type: none"> <li>• I was trying to speak to them [ward staff] but I just got no response. It just felt that they just weren't listening when I was trying to speak to them.</li> <li>• He's [psychiatrist] just not interested in me.</li> <li>• You've been saying that I've been dressed nice or that I talk nice or you know, looking in your eyes...but you're not actually seeing anything that is going on beneath because it's not in your field.</li> <li>• I feel very, very let down that you're crying out for help and they hear what you are saying but because they have to do the paperwork and everything like that it's, it used to make me feel that they can't be bothered with me.</li> <li>• They don't seem to understand. They don't take the time to listen. They just do medication and they're too quick.</li> <li>• It's as if I'm not in the room.</li> <li>• [Staff on the ward] were antagonistic, ignoring me, not creating an atmosphere where I was encouraged to talk.</li> </ul>



			<ul style="list-style-type: none"> <li>• I couldn't put it into words at that time how I was feeling but at the same time nobody really wanted to find out.</li> <li>• They've known me for years so they think oh let her shuffle up and down the corridor because as long as they are locked in, why should we care? As long as I am not endangering myself and others they don't care, they just don't care.</li> </ul>
<b>Dependency</b>	Sense of wanting to be cared for by services	<p>Wanting care Services providing the care people want Dependency on services as seeking out support Self-harming for more care to be provided. Self harm leading</p>	<ul style="list-style-type: none"> <li>• I cut my neck open and she came down to A&amp;E and sat with me and that was the happiest I'd ever been because I had that care that I wanted but then others, that possibly wasn't helpful though.</li> <li>• It was like a vicious circle going round and I was just in and out of hospital but at least in hospital I felt cared for.</li> <li>• I felt cared for. There were medical staff there so whenever you're in a hospital you're cared for so I think that helped.</li> <li>• They were like drugging me up and once I was back on a level and I was ok for a while I was then discharged and then I'd hurt myself again so no one was actually getting to the route of the problem and nobody really seemed that interested apart from when I really hurt myself.</li> <li>• I'd hurt myself because I knew I'd go back to hospital. It always felt a bit better there.</li> </ul>
	Isolation leading to dependency		<ul style="list-style-type: none"> <li>• I'd even phone the [psychiatric] ward some nights just to talk to somebody and sometimes they would talk to me for a while but not often and that's because I had no one else to talk to.</li> <li>• I used to just isolate myself really. It was only my partner and my mum and dad so I'd come here and feel better.</li> <li>• I don't have any fiends so my sense of isolation was very real but at least I could talk to my therapist and that helps.</li> <li>• I don't have any friends really outside but I like the staff here.</li> <li>• You know, having these behaviours means you can distance</li> </ul>

			<p>yourself and become very isolated and lonely. Then when you're out you can't see the best in life and I can't be a part of that nice life so you can put yourself down so I end up back in hospital and that's not good, is it?</p>
<b>Symptom management</b>	Medication unhelpful	Theme around un-treatability through medication Unhelpful to give medication for BPD Doped up Drugged up Feeling drowsy Cocktail of drugs given Sense of being over-medicated	<ul style="list-style-type: none"> <li>• A lot of doctors will just say "well, have some tablets, just have some tablets" but that's not going to really take away any of the problems that you have got.</li> <li>• Medication's not going to teach you how to deal with it. All it's going to do is suppress your emotions.</li> <li>• All medication does is push your problems away, hides it, suppresses it and calms the emotions down instead of actually facing up and dealing with the emotions.</li> <li>• It seemed like they were going to prescribe this for me and I've always been anti-drugs rather than going for where the problem is... it didn't help me understand what was going on.</li> <li>• [Talking about addiction to medication and manipulating psychiatrist into giving more drugs]. In the end I had to personally stop seeing the psychiatrist. Especially when I was thinking at the time that I could sell this stuff on the street to people that wanted it.</li> <li>• I was just drugged up to the eye balls.</li> <li>• [Talking about medication] I was slurring my words and no one could understand me.</li> <li>• All they seemed to do was pump Lorazepam in me, injections of Lorazepam which knocked me out.</li> <li>• [Talking about over-medication] I didn't want to take too much medication because I didn't want any harm coming to him [baby].</li> <li>• I've been given ECT, I've been on Lithium, I've been on all kinds of anti-depressants and most haven't helped.</li> </ul>

			<ul style="list-style-type: none"> <li>• We'll give you the pills and keep increasing them until you reach a point that they are happy and you don't really know what is going on.</li> </ul>
	Patching up symptoms	Not fixing underlying problems Not getting to root of problem Not really feeling anything CBT and patching up problems No quick fix	<ul style="list-style-type: none"> <li>• I used to go to A&amp;E and they would stitch me up, give me medication, and send me off home. There was no offer of a programme to try and support me to try and get through these problems and so the psychiatrist used to come up and have a few words and then he used to send me home.</li> <li>• I find that CBT it may fix the problem temporarily for that moment but it doesn't actually deal with where the underlying issues are.</li> <li>• They are employing loads of these CBT people to whatever to give an instant fix thing which is fine again but actually I don't know whether people want that instant fix.</li> <li>• I had CBT and I could get to grips with this and understand what it was trying to do and yes, I did get a toolbox...but at the same point it didn't seem I don't know, intense enough to actually find where it was going, the root problem.</li> </ul>
<b>Dis-empowerment</b>	Ward environment and abuse	Trauma of ward environment Re-traumatising experiences Re-experiencing traumas Abuse on the wards Harmful to be on the wards Not feeling safe on the wards	<ul style="list-style-type: none"> <li>• I got touched up by a staff member so I remember that. I ended up cutting myself because of that because I thought it was my fault as you would.</li> <li>• You're obviously in there to get better and to be safe and then I obviously didn't feel safe.</li> <li>• Being under section all your rights are taken away from you and that feels terrible.</li> <li>• When I was in hospital a couple of years ago I felt they were very uncaring. It can be pretty brutal sometimes the care you get in hospital. It wasn't very caring in hospital.</li> <li>• There was always someone kicking off in hospital, smashing plates and fighting.</li> </ul>

			<ul style="list-style-type: none"> <li>• If you go to have a bath, even if somebody is escorting you in to the bath making sure you have the bath that's when you start to feel the intrusion of privacy starts.</li> <li>• I've found it so far quite scary. All the sorts of behaviours I've come across, screaming, crying, smashing things, hitting out, kicking and punching. That's what I'm saying is scary because you don't know from one day to the next what's going to happen and so unpredictable.</li> <li>• On the wards they have sworn at me. They think you're so bad that they can swear at you if you don't get along with them.</li> </ul>
	Unhelpful power differences	Dislike rules and structure Lack of respect for clients Hierarchy in staff teams unhelpful Lack of rights when sectioned	<ul style="list-style-type: none"> <li>• There are a lot of people [clinicians] it goes to their brain or they are too high and mighty to come and speak to someone like me.</li> <li>• There's a non-empathic way about it [seeing psychiatrist], it's very clinical, I am the doctor and you are the patient.</li> <li>• The nurse said you know you were really right there and I said well why didn't you say that in the room? Oh we can't because it's the consultant.</li> <li>• Just drag me into hospital whether I like it or not. Some of them don't even give you the option of whether you want to go voluntary or not. They just section you and that makes me angry.</li> <li>• I've found that there hasn't been very much privacy [in hospital]. I feel quite powerless.</li> </ul>
	Empowerment through diagnosis sharing	Diagnosis empowering people to learn about difficulties Relieved by diagnosis Helpful as gives you better understanding Relief through information Unhelpful to be	<ul style="list-style-type: none"> <li>• I was actually relieved to have the diagnosis as I had been in the system for 20 years and been diagnosed with bipolar and just clinical depression. So I was actually relieved to get a diagnosis, a correct diagnosis that I could read about.</li> <li>• I was relieved. I was relieved to be able to put a label on it or to be able to describe it and give me something to look up on the internet, something to read about.</li> <li>• I've got a personality disorder well I don't live in that, I don't use it</li> </ul>

		<p>misdiagnosed Incorrect information being un-containing</p>	<p>as a crutch but it just enabled me to understand and read up and look at it more and put things into perspective.</p> <ul style="list-style-type: none"> <li>• I did have many different sort of diagnoses just like telling me that I was a paranoid schizophrenia, I had split personality another person said I was emotionally unstable and it's not very helpful really as you feel confused.</li> <li>• I was never actually given that label or that diagnosis of what could be wrong with me for many years so when I did I felt I had a better understanding of my difficulties.</li> </ul>
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**Appendix 16: Research diary excerpts**

Date	Diary entry
February 2008	I have received information about the potential topics from the research fair and I am struggling with which of these topics I would like to do. I feel stuck as I am interested in borderline personality disorder but I cannot see any potential projects based on this. I have also checked the Salomon's list of research interests of people within the department and I cannot see anyone interested in BPD. I will need to approach Salomon's about potential internal supervisors with a specific interest in this field. I will email Sue about potential sources. I really want to look at this topic because I have worked in a number of teams where I have been struck by the stigma around this label and whether people can be treated. I think the issues of stigma and having this diagnosis would be an interesting area to consider.
April 2008	I am concerned that I will not be able to find supervisors interested in this area of research. I have contacted a few clinicians from various services but I have not heard back from them or they have told me they are too busy to help. I am feeling disheartened with trying to go forward with this research idea. Maybe I should use one of the projects that is already suggested from the research fair?
May 2008	<p>I had a meeting with Ann today and she explained that there are a couple of people I could approach to be potential external supervisors. I feel much better for having seen her and she felt my project might be of interest. She also explained that John McGowan has an interest in personality disorders so I will arrange a meeting with him and see if he can supervise me.</p> <p>I went to see someone from the PD Unit in Camden and Islington Trust today and he was very helpful with thinking about why I might be researching this area although he felt he did not know enough about stigma and social models of understanding this disorder to help me. It was good to have finally met with someone external to Salomons to talk through my interested in stigma but I am starting to think I may need to change my research idea as people I am speaking to seem to lack interest in this area. I have also checked to see what the current research evidence is and there seems to be literature in this field although I could still potentially make a project out of this.</p>
June 2008	<p>I had my meeting with John today and it was really positive. I really liked the fact that his mother's book on personality disorders was one of the first books I ever bought when I first started working on a psychiatric inpatient unit. I loved this book because it gives a real understanding of service-users experiences. I must re-read this and familiarise myself with the book as I remember it being very helpful.</p> <p>John explained that he has an interest in personality disorders although again, he wondered whether it would be a difficult topic to research. I am also coming to the conclusion that this topic area might not provide much helpful information for people with this diagnosis. We already know that people are stigmatised when they are given this label and I am starting to consider that I might like a more positive aspect to this research. I would really like to make a difference and I am still unclear how I can use this opportunity to really gain service-user views and hear their voices in the literature. John gave me a list of potential external contacts to email as potential supervisors and suggested I read „therapeutic communities“ by Campling &amp; Haigh.</p>
July 2008	<p>No luck with any of the external supervisors. This is becoming a complete nightmare. What won't anyone at least consider helping me? Oh well, back to the drawing board.</p> <p>I had a meeting today with Ruth Chester, a colleague from my placement. She mentioned that her thesis was based on how teams communicate and make decisions about service users with a diagnosis of BPD. I was really excited to hear this and</p>

	<p>asked if she would be interested in talking through my potential project and possibly being my external supervisor. She agree – hooray!</p> <p>The meeting went well and she explained that she felt my research question was too vague and possibly too difficult to work with. We had a great meeting where we both brainstormed a number of possibilities. With both of our interests being very much about the service-users their voices being hear we decided on the topic of recovery. This totally fits with my desire to have a more positive slant on working with this client group and would marry up with Ruth's previous research so as a possible joint journal article could potentially be written.</p>
August 2008	<p>I have been allocated John as my lead supervisor and Ruth as my second so now I need to really start thinking about my research questions in more detail. I am reading a lot around recovery and various different types of services available for people with a diagnosis of personality disorder. I really want to look at BPD alone but I think this might be too difficult to get enough potential participants so I will stick to PD in general.</p>
September 2008	<p>Met with John today and we worked through some more of my ideas. We discussed the recovery model and whether it is applicable to this client group. We considered whether it might be more useful to think of how services are helpful for people with this diagnosis. In particular, how services relate to people with this diagnosis. I felt a bit confused after today's meeting as I really want to look at recovery and this does not feel as exciting as the recovery model. I believe people can recover from PD but then John felt that this is medicalising the problem and is possibly unhelpful to consider it in this way. I wonder if looking at what is helpful is another way of considering recovery?</p>
November 2008	<p>Met with John today to discuss my proposal and give him my draft copy. He said it looks OK but that we need to consider the introduction section in more detail. I am finding this hard as I am still trying to get my head around what it is I am really trying to research. I need to really think about how services relate to people with a diagnosis of personality disorder. This feels so broad to me.</p> <p>Had a great meeting with Ruth last night. It felt more relaxed meeting at her house and going through my proposal there. She was such a great help having given me all of her articles she used for her thesis. It was a bit daunting to see how much reading I have to do but then I thought some of this won't be relevant and it is good to start broadening my knowledge in this field. We discussed what she would be involved in and she said she will help with all areas with regards to recruitment, reading through my ethics forms and IRP and being there to support me emotionally when it gets tough. I feel this will be valuable when I am panicking over my IRP.</p>
December 2008	<p>This research proposal is quite tough to form. I need to be clear about my research aims but this is causing no end of struggles. I am finding it difficult to be concise and my introduction section feels so broad. I mean, what is helpful? This could include so many themes or areas (e.g. psychological therapies, teams, clinicians, the individual themselves). How do I fit the research evidence into such a small area? This project feels so vague to me still. I'm not sure I really know what I am doing!!!</p> <p>I had a three-way meeting with Ruth and John today and this was really good. It felt helpful for us all to meet and thrash out our ideas.</p>
January 2009	<p>Ah, this research proposal is really getting to me. I need to get it in for the deadline and I feel like it's not as good as I would like it to be. I met with John today to check through the final draft and he thinks it is OK apart from to change a few of the ethical</p>

	<p>considerations. I'm not sure about my semi-structured interview schedule too as I have thought about these questions quite quickly. More thought needs to go into these but I feel I don't currently have the time with the deadline looming. At least my participant information sheets are complete but they do seem a bit too long. Will people be put off by my research if they see these sheets? I think I've considered the ethics quite well and it seems to be good enough to hand in but I wish I had more time to work on this. I have put a lot of work into this proposal but it still feels like there is so much more to think about (and I still don't know if I truly understand what I am doing).</p>
February 2009	<p>I've just had my review panel for my IRP and it went really badly. I felt so upset during the panel interview but I'm not sure if it was because I felt I did not know what I was talking about. I am worried that when it comes to my viva's I am going to be exactly the same. I am so bad at being interviewed and I am concerned this will be repeated when I go to viva. This will need some personal work on my behalf to feel more comfortable with being interviewed about my research. I knew the thing that was going to pull me down was my introduction section. I couldn't even talk about the different types of personality disorder and what they are. I must have seemed awful. I think it is correct that I go away and try to re-do my introduction section as requested as it is difficult to understand what I am actually doing. I also agreed that my participant information sheets needed re-doing. They are too long and there were a few miss-wordings. This process feels so upsetting when you know how much work you have put into this.</p> <p>John and Ruth have been supportive about this. John and I met and have gone through what needs to change so I'll get on with this over the next couple of weeks. I need to include more about personality disorders and make the introduction clearer.</p> <p>Wow, had a great teaching session today on interviewing. I brought in my semi-structured interview schedule and learnt a lot about what questions are useful for grounded theory. This includes having questions that provide a more detailed picture. This is done through questions such as "what did you think/do/say/believe/feel etc". I noticed I had not included the full range of open-ended questions and would need to change my schedule. It was really helpful gaining the input of my small group too as we worked through my interview schedule. This was such a great teaching session and I am glad I was brave enough to bring my schedule in. I learnt a lot today!</p>
March 2009	<p>Been working on my proposal again today – feeling a bit bored of it now and think it's time to hand it in. I met with John and he thinks it is a lot better now and Ruth read through it and thinks it is OK.</p> <p>Fantastic, I got my proposal back and written confirmation that Salomons have agreed that the study is viable so I can proceed with my ethics application.</p>
April 2009	<p>I had a meeting with Ruth today to go through how ethics works and to get some advice. I had some bad news as Ruth told me that she will be going on maternity leave in October. I felt happy for her but I'm now a bit concerned that she is having her first child and will not be around to help with the project. I will also need to involve another person in the Trust as Ruth was going to be really helpful with gaining potential contacts through the Trust.</p> <p>I had a meeting with John to discuss this issue and he suggested I consider that Ruth might not be available to help with the project as it is her first baby. He felt she might be very busy and that I should consider finding a back-up supervisor. I am thinking about my old supervisor from when I was in my first year placement as he knows Ruth</p>



	<p>and has good contacts at the Trust. I also know that he is really good at research and is someone I find easy to talk to. I'll contact him once I've spoken more to Ruth about it all.</p>
May 2009	<p>Ruth feels she can still help me with looking at my ethics form and draft thesis but I'm going to need help with getting contacts as I'm not going to get my ethics form in for a while. She agreed with me that Chris will be a good person to ask.</p> <p>My ethics form is driving me mad. It seems so repetitive. Still, it's getting me thinking about how my research will actually look when I get started and it's good to fully consider the ethical implications. I'm mainly concerned that it might be distressing for people with personality disorders. I hope it goes through ethics without too many problems.</p> <p>I feel so behind. Whenever we have those small research groups I feel like it's only adding to my anxieties. Everyone else has been through ethics and some are collecting data yet I'm still at the ethics stage. Still, it was helpful considering positivism versus social constructionist approaches today. It's made me think about my own research and to think of some of the flaws with a social constructionist methodology. It was good to argue in a debate form as it really got me thinking of counter-arguments. This should help me in my viva although it does seem a long way off!</p>
June 2009	<p>I met with John today and we went through my ethics form. I think I'm getting there and he seems to think I can send it soon. We continued discussing my research idea and picking up points about how services relate to people. In particular, we thought about the role of risk, dependency on services and what happens when people with this diagnosis are hospitalised. It was an interesting supervision session and it really got me thinking. I must re-read the Castillo book on personality disorders and do a bit more reading around risk management with this client group.</p> <p>I emailed Ruth a copy of my ethics form and she has suggested a few changes but she thinks it's fine and just needs to be sent. I'll do the changes then book in the dreaded ethics panel. Not sure how to do this yet as this IRAS site is so confusing. I'll check with some of my year to see what to do.</p>
July 2009	<p>I have finally submitted my ethics form and I think I'll have a break from it all for a while. I can't believe I've got to wait until the end of August to go to the panel. Such a long wait from now and I was hoping to start interviewing over the summer period. Oh well! I must say, that was a massive rush though getting the final ethics stuff together. I had to rush so much and it was all quite anxiety provoking as I knew I only had 4 days to get it all in. I'm also surprised by just how many copies of everything were needed.</p> <p>I had a meeting with Ruth and Chris today and it was decided that Chris would like to help out with the project. His role will be to act as a contact point to guide me to various professionals. I hope he'll be able to help with recruitment as that's my biggest anxiety at the moment.</p>
August 2009	<p>I attended an away day on emerging personality disorders today. It was so interesting hearing about personality disorders from this angle and working with my client at the moment who possibly has an emerging BPD. It got me thinking about the more psychoanalytic perspectives and MBT with younger people. It seems important that more early intervention services are available but whether the name needs so change to make it more appropriate.</p>

	<p>Considering how scared I was the ethics panel was actually OK. They all seemed really nice although it was daunting having so many people sat around the table. I also could have answered the questions better and defended my project more but I think I just wanted to get it over with and for it to get through ethics. I have a few alterations to do but nothing too major. I'm actually quite pleased about one change – making the project about BPD rather than personality disorders. I think this might be harder to recruit but it actually makes more sense to look closely at one type of personality disorder. I'm not so keen about changing my consent form though – seems a bit pedantic to me.</p>
September 2009	<p>Great, I've received my letter from the ethics panel saying I have ethical approval. I've sent off all of my sheets etc to Oxleas research committee so I hope to hear from them soon too.</p> <p>Got my R&amp;D permission today so I can start recruitment. I'll start with my old placement since I know a few friendly faces there and my external supervisor is based there. I'm thinking it should not matter too much who I interview first since my first interview will prompt me to think about who to interview next.</p>
October 2009	<p>I visited a CMHT today about my project and people seemed really interested. I've got a few potential participants to start with. It's good that I've got a CMHT on board but I'd really like to hear from some of the other more specialist teams. Even though I've contacted an MBT team, DBT specialist, and a couple of other CMHTs no one else has got back to me yet. Next step, I'll call them and see if I can't come to a team meeting and present my research to them.</p>
November 2009	<p>I saw John today as I am really worried that I'm not getting any participants. I wanted to have ideally finished interviewing people by now but I haven't even started yet. He settled my nerves though and suggested possibly contacting another Trust to see if they would like to participate too. Maybe Kent would be good but I have limited contacts there. The other choice is SLAM but I think they are usually quite difficult to get through R&amp;D or is that me being biased? I'll check with my old colleagues in Lewisham and see what they think.</p> <p>Fantastic, I've just spoken to two clinicians who are willing to be interviewed. Now I am feeling anxious as they are both psychiatrists. Also, I was not sure that I wanted to interview 2 from the same profession first so I may keep one until later and ask her to wait until after Christmas so I might be able to interview a different clinician from another profession to see what their views are and whether they are different to the first interview.</p>
December 2009	<p>Great. I've just finished my first interview and can't believe how interesting it was. I was anticipating this interview to be fairly difficult and was worried it would be lengthy but it only actually lasted 40 minutes. He spoke about so many interesting areas that included his beliefs about medication being harmful, the need for services to take more risks and for services to stop being so inconsistent in their responses. This really seemed to fit with some of the literature that suggests risk and responsibility are important factors in services. I thought it was really helpful that a psychiatrist could speak so openly too about how medication might not help yet he often feels the need to "reach for his prescription pad". He also spoke about the problems associated with CMHTs and inpatient units that fits with Paris's suggestions. There was a very strong theme around risk and responsibility and for services to stop responding and reinforcing dysfunctional behaviours. He mentioned a lot about dependency too and the need for services to reduce this.</p> <p>I think it would be great to interview someone who was less based in the medical</p>

	<p>model next and who might not be so concerned about risk to see if this still comes up as a theme that needs further looking into. I'm thinking it would be helpful to interview a psychologist or psychotherapist. So far, I've got an MBT therapist who has said she will participate so maybe I'll try her next since her model of working should be very different to my first interview.</p> <p>Good news, I now have R&amp;D approval from KMPT. I decided on this Trust since I wasn't too sure about the ethics process at SLAM.</p>
April 2010	<p>Oh my goodness, I'm going back to college after nearly 4 months of sick leave and I am very worried about catching up with this project. I can't even remember where I was at and how I was thinking. I'm not too sure I can realistically get this handed in this year. I'm doing a 4<sup>th</sup> year anyway so maybe I should try and work through this next year.</p> <p>Being off work and having to be a mental healthcare service user over the past few months has really changed my perspective on this project. I hope I don't bias the results now. I think I should write down my experiences of being in services so I can reflect on them whilst doing this research as I am really mindful of how strongly I have felt at times.</p> <p>So, I know that A&amp;E is a place I really dislike having been in there for physical illnesses and through feeling unhappy. I felt awful going in there and I found the nursing staff fairly unsympathetic. I can't imagine this experience would ever be pleasant but I noticed how poorly trained clinicians are and how unsympathetic people can be at times. I wondered if they just couldn't understand why someone would behave like this and that they could not see the sense in it. I imagine they see a lot of it all the time. My referral to psychiatric liaison was OK although it was very late at night and I was escorted there by a nurse and security. This made me feel powerless and thought that this was possibly how people must feel when they are being escorted to hospital. In fact, I didn't really know if that was where they were taking me and I felt frightened.</p> <p>Psychiatric liaison was in the mental healthcare unit and it was dark when I arrived. I was made to sit in the dark, on my own. Looking back, I think this was very rude and disrespectful but at the time I just didn't care and welcomed the darkness to rest a little.</p> <p>The junior doctor was really lovely. I was pleased that he listened to me, gave me treatment options that I could choose from, and that I would be seen later that day by a colleague. I think this type of response was really helpful. The decision was made for me to see the home treatment team. My experience of this was mixed. I liked going to the Unit rather than them coming to see me as it got me out of the house. However, some clinicians lacked understanding and wanted to think about solving problems quickly when all I wanted was someone to talk to. However, once more, I was treated with respect. The building was kept nicely and I could go there as and when I chose. They even supplied refreshments and sandwiches which felt as though they really cared. This was all really good and I found it helpful to have a crisis number to call too. However, being sedated and discharged after 2 weeks was unhelpful. I was still so volatile and I'm not sure this is very good. Mind you, at least they prevented an attachment fully forming since I was always seen by different people. This seemed OK as they all shared information well.</p>

	<p>My experience of the CMHT has been less helpful. I'm not sure how they can help though. I'm not willing to take medication, I'm in therapy, and I don't need housing help etc. Also, being a professional service-user is hard since I have even had an appointment with someone I worked with so the confidentiality issue has been problematic.</p> <p>So, I've got to keep an eye on my feelings about this topic now. I am hoping people's experiences will be different to mine so that it is less likely that I will bias the results. I don't want to overly identify with participants as this may lead my questioning and reduce the reliability of the data.</p>
May 2010	<p>I've just completed my second interview with an MBT therapist. There were still strong themes around responsibility but interestingly, she discussed more about needing a shared model of understanding and sharing risk. She felt it was important to work as smaller specialist teams as CMHTs are too chaotic and fragmented. So, she still shared views around dependency risk and responsibility but there was more about attachment and shared ownership. She did talk about services needing to form trusting relationships with people too that seemed useful. It would be great to interview a service-user soon but I am totally struggling to recruit people. As with interview 1 there is something about being boundaried and firm or as clinician 1 said, "rigid". I think they are all suggesting the same thing, being more formal and detached. With regards to clinicians though, I think it would be helpful to interview a psychotherapist to hear whether these views are shared within a more psychodynamic framework. I think I'll contact one of my participants to arrange this.</p> <p>Had a meeting with another CMHT today and they are on board. I also have my first contact for a service-user participant. There were a couple I could choose from but this one felt more appropriate since she is nearing completion of treatment.</p> <p>I completed 2 interviews today. A service-user interview and a clinician interview. The service-user was really helpful. She talked about wanting to be in services and there was a strong theme around feeling abandoned and rejected. this was a particularly isolated individual so it might be helpful to hear more from someone who is less isolated to see if this theme of seeming to want to be in services appears. This interview was difficult as I felt she was trying to push my own boundaries. She was very friendly and at times she threw questions at me that felt difficult in the interview. She also seemed really quite dependent on services and even in the interview it was hard to end and it was as though she wanted me to be able to ask for more help for her. Throughout her interview was a strong theme around needing help and fighting for help to get it. I felt there was a lot of determination in her requests for help from services.</p> <p>The clinician interview went well. He is a psychotherapist and mainly talked about how difficult it is to work within short time frames of the NHS. He felt symptom based approaches like CBT and where there are time restraints on treatment are unhelpful. He suggested the importance of a secure attachment and like the other interviews, he described issues of risk, responsibility and services reinforcing problematic behaviours.</p> <p>I have just visited a TC and they have agreed to participate. I even got to interview a couple of people there and then. The first person was actually similar to the first</p>

	<p>service-user since she too was isolated but had been in the system for many years. She was very reflective and was able to talk about feeling dependent on services, wanting to be cared for and feeling secure with certain therapists who she described as being parental figures. She also felt the TC was supportive and felt less isolated because of this. She appeared to have a very strong attachment to services. A key theme around attachment seems to be suggested in these interviews. The second service user was a male who had not been in services as long and was less isolated. He talked a lot about his experiences of wanting to be cared for, feeling that he wasn't listened to on the wards and that it was unhelpful to have inconsistent responses. Both actually talked about the ward environment feeling disempowering and possibly even abusive.</p> <p>Oh God, I've just done my first line-by-line coding and this is so hard. I have absolutely loads of codes and it has taken me a day to do this. I'm going to do 2 line by line coding for service users and clinicians interviews before moving on with the coding process. It feels impossible to pull out themes right now and I think I will need to speak to my supervisor about this. I'm worried as it feels that what is helpful is such an individual thing and could it be that what is helpful is not so much about what disorder a person has been given but what the individual views as helpful no matter what the diagnosis.</p> <p>Just interviewed a nurse CBT therapist. I chose her next as I thought this would be interesting since the last interview suggested brief interventions and more medicalised approaches are unhelpful for this client group. The themes that came up from this interview were once more about risk, responsibility and trying to avoid dependency. She talked less about forming an attachment in the more obvious sense but described services needing to be consistent, information to be shared, and for trusting relationships to develop. She also talked about boundaries and needing to be clear about these. This felt similar to other interviews and very little new information came out of this interview. However, she did mention more about links between services and the need for supervision and training within nursing teams that had not really been discussed in other interviews. I wonder if interviewing someone from the TC would be helpful for seeing if their views differ. I'd like to hear more about groups and whether this helps from a supportive angle that service users have suggested. I will consider changing some of my questions to consider the themes raised so far in previous interviews. I think I really want to hear whether people's views vary regarding dependency, attachment, and responsibility. I am also aware of my own biasing in this process. I don't want to look more at certain themes based on my own experiences. I am aware how the interviews have made me feel and in particular I am trying to pay attention to my own thought processes.</p>
June 2010	<p>I feel like I am fully immersed in the coding now. I have spent the last few days analysing the first 4 interviews and this is hard work. However, I am starting to see themes emerging. There is certainly something around dependency, risk, responsibility, medication and hospital being difficult experiences. Having a good attachment and feeling secure within a trusting and bounded relationship also seems important. Mind you, there still seems like so many codes and I'm not even sure I am analysing this correctly. I mean, how am I to know that the themes I am pulling out seem to match what is in the dialogue and even more, surely I am biasing it with regards to the bits in the interviews that seem most useful. Collecting these themes is hard work, having to sort so many words, phrases and descriptions into different piles. I've got so many bits of papers with descriptions on. Still, I think it's quite helpful just placing them into various piles on the floor and sorting them from that. I think I need</p>

	<p>to check with my supervisor that I am doing this coding correctly before I attempt anymore.</p> <p>OK, saw my supervisor today and he thought I was making good headway. We went through my coding and I explained what I had done and he thought it was OK. However, there were some queries about my potential axial coding and whether I am forming accurate sub-categories from these. It was helpful to have a fresh pair of objective eyes on this and I feel OK about continuing with the coding now. This meeting did make me realise that I have biased some of the data slightly and possibly need to reconsider my data (e.g. over-emphasis on pathologising nature of diagnosis).</p> <p>I interviewed 2 service-users at the TC. Both were quite different. The first interview was a male who had some experience of mental health services whilst the female was young and had a great deal of service use and seemed a lot „sicker“. His interview went really well. I warmed to him and had to be aware of this not biasing my questions during interviewing. He described difficulties on the ward and the sense that he was not listened to nor understood. He felt people never tried to understand his problems and a strong theme around being misunderstood, belittled and ignored was felt during the interview.</p> <p>The next interview was with the young girl and I chose her next as I felt she was different to the last interview since she was much younger and seemed to have had a lot of experience in services from a young age. This interview was really hard. I didn't realise quite how unwell she was. I struggled with this interview as there was nothing she found unhelpful. In fact she found the very things that everyone else had found unhelpful, helpful. It was difficult to not bias the interview as I felt her views were so extreme compared to everyone else, including my own. I was quite shocked when she said she found ECT really helpful and that the most help she could have was to be placed in a room with constant ECT. This was quite upsetting to here but I also wondered whether the fact that she seemed a longer way off recovery might have played a part. I'm not sure she was fully able to reflect on her experiences and she also was psychotic. I wonder if this could be a negative case? She fitted with the helpful aspects of services such as talking about forming attachments but she seemed completely unable to consider anything as unhelpful. My feeling after this interview is that feels so different. I need to code it up and see what comes up. I might be biasing this somewhat and need to interview others to see if her views match other peoples.</p> <p>Once more immersed in the coding. My last interview certainly is not fitting in well at the moment but some of the more helpful themes fitted. I'll keep coming back to this one as my research develops. My other coding seems to be coming on though and I feel like I have an idea around an attachment model of service relationships. I've started to produce this but it's in the very early stages. I'm thinking it's something around showing the most insecure services to the most secure being those which are trusting, consistent and all the aspects of attachment commonly known. I read up on some attachment theory and this seems to fit with relation to services. I don't think anyone has formalised a model like this yet so I feel quite excited by this. Maybe there is light at the end of the tunnel. I'll check with my supervisor but this really is taking shape. The more I have analysed the data the stronger these themes seem to be appearing. I don't think I am being biased either as I have been keeping such a critical eye on this and reminding myself to be aware of my potential biases as I've been analysing.</p>
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	<p>Just interviewed a group analyst and a psychiatrist at the TC, and two service-users. This was quite a good day since I was able to interview so many people with such varied backgrounds. It was good to hear more about the TC model and to consider the role of responsibility and dependency in more depth. I was also really able to consider my recent coding experience and think about how that shaped the interview. In particular, it was useful to be able to draw out themes and asked about hospitalisation, attachment, consistency, and relating to people with this diagnosis instead of sticking to the original interview schedule. It seemed to flow better too as I was able to reflect on what people were saying and consider how it compared to other interviews. With regards to the psychiatrist, I was really interested in what she said about services being unhelpful when they do not take positive risks and how problematic the inpatient environment was. This reflected other interviews and I felt that very little else came from this interview. Mind you, this is possibly me biasing by even saying that. I must analyse the data first before deciding nothing new is occurring.</p> <p>I also interviewed two service users today. Again, they were fairly different. A male and a female of which he male had struggled with his identity for years whilst the woman was a lot older yet seemed to have managed for years without the need of services. She did not seem the „typical“ BPD service-user so this was useful for the analysis. Both actually spoke about the same difficulties with services even though they had both come from very different backgrounds with very different mental healthcare experiences. They were both able to talk about needing a trusting relationship, struggling when therapists are not containing and feeling that some services are excluding or not interested in them. Both did not see their label of BPD as problematic and found it useful. They talked about the TC positively and felt it was good as they were supportive and focussed on relational difficulties rather than symptom based brief therapies. There was also some sense that boundaried clinicians are vital for feeling safe and that consistency was vital.</p> <p>I interviewed my old supervisor today. I’d wanted to interview another CP since I thought they might have useful experiences that might differ from others interviewed. In particular, I chose him as he works in a CMHT and works psychodynamically and systemically. This was such a good interview. I was really able to consider my recent analysis and to ask more about those issues identified (risk, dependency, consistency etc). His interview seemed to really expand on the themes I was already considering. It was difficult to not feel excited since this matched so well. I am going to need to check for biasing when I transcribe this one but I actually think it’s because he was telling me stuff that really sounded similar to the analysis.</p> <p>Yes, it looks like my data isn’t really producing any new themes. My last clinician interview certainly seemed to fit the analysis although I would like to get one more interview to check no new data is being identified. Maybe I have reached saturation. I certainly hope so! I also think my model has come on a lot more. I now have a whole revolving door/dysfunctional relationships versus secure attached services framework figure to check against. I also looked at my negative case and it still does not really fit. I need to book a meeting with my supervisor to talk this through!</p> <p>Excellent, my supervisor likes my model and thinks my themes are coming on nicely, I’ve managed to form categories and subcategories from the coding but he did mention that some of my quotations are possibly not truly matching the categories. I’d better go and re-jig this a bit.</p>
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	<p>Good news, I have a rehab service on board. Looks like the inpatient rehab unit will participate and they have a few potential clients I can interview.</p> <p>I interviewed a service user today from a rehab unit. This was a difficult interview and I don't think anything came from this. Please don't tell me it's another case that's not fitting the model. She was fairly unwell and maybe I shouldn't have interviewed people from a rehab unit but then this is supposed to be a unit designed to help people recover and move back to the community.</p> <p>Actually, just analysed this data and it seems OK. Some of it was difficult to include but then other aspects were able to be placed in the coding I already have. Maybe it wasn't so bad after all. Mind you, no new categories came out of this so I think I'll try to do one more interview and hopefully I'll have reached saturation.</p> <p>I've just completed my final interviews with a nurse and a service user at the rehab unit. This was a success since the service user was very engaging. I wasn't expecting this at all and it was quite a relief after the other week's difficulties.</p> <p>Both interviews discussed themes already suggested and in particular I was really struck by the service users experience of inconsistency with clinicians, abusive wards and feeling abandoned and rejected by services. This was so useful to hear. The nurse also described staff needing to listen, care and loom after people. He talked very much about his role being to provide a secure attachment and to help people recover and find meaning in life. He also talked about the issue of boundary setting and for staff to give consistent responses and to be compassionate towards people with BPD.</p> <p>After analysing these last two interviews I think I can well and truly finish interviewing!!! I actually can't believe I've interviewed so many people in such a short amount of time but I really feel doing this project full time is giving me the chance to almost "live within" the project. I feel like I am so fully immersed in this that it must be helpful (or maybe I am too into the data now). I have also been wondering how much of this analysis I have been thinking about without actually having the codes here in front of me. I feel like even listening to people, transcribing the data and doing so much reading about this topic is adding to my understanding. This is surely biasing how I am thinking and what I am analysing. Still, I have a model, my categories seem to fit but I do keep swapping things around. I imagine this can keep happening though.</p>
July 2010	<p>I've started to write this all up and its very hard. I am worried about how much I have used the grounded theory. So much of my analysis felt subjective and it's hard to remain objective. I suppose the critical realist stance helps with this but still, it is a stance position to take and one I am not used to taking.</p> <p>Oh my goodness, I've been looking at my categories today and I am now wondering whether I need to re-look at the role of . I'm going to have a look at some of the transcripts and see if this matches up and whether I need to change this around a bit.</p> <p>Thank goodness for that. I have finished my IRP! I have sent summaries to participants and the ethics panel. It feels like the end is in sight and I feel happy that I have got this far.</p>



**Appendix 17: Excerpts of sample memos****Memo 1: Sense of belonging**

I have interviewed four people now and they have all said that service-users feel a sense of belonging in services. In particular service-user participants have said on numerous occasions that they have felt that being able to talk to others with similar problems is useful. There are a lot of comparisons in these interviews and they often discuss feeling isolated in society. There is also a theme around people feeling invalidated in society or that they do not feel they can trust others enough to form close friendships. Being with other people who have similar problems seems to be validating for people. Participants have talked about this in reference to self-harm. They have often discussed how other people do not understand this behaviour but that they feel a sense of belonging and safety in knowing that others share this difficulty, normalizing problems. The first service-user participant talked about being extremely isolated in society but finding a few friends through services. She explained that it felt like she belonged with these people since they might not judge her. The second interview was also with a person who was very isolated but was able to talk about valuing being a member of a community. She was in a therapeutic community and said it had been very useful as she had formed friendships and no longer felt as though she had to manage problems alone. This was someone who had been in the system for a long time and during her interview this sense of belonging seemed like a very strong theme. Since then the other two interviews have also described people finding it helpful to be a part of a group atmosphere and feeling comfortable with others who understand and share experiences together. There is a sense of acceptance in being with people with similar difficulties and whereby they do not feel judged. It seems it is a place where people are more equal compared to in society where people often feel excluded. There seems to be a theme around fitting in and particularly having a sense of belonging.

June 2010

Most participants have talked about how important it is to feel accepted within a group and that helpful services provide this for people. Both clinicians and service-users have talked about belonging when people are so often excluded. This seems important as people have also talked about services where they have felt as though they do not belong and have been excluded. This is the complete opposite of helpful services. Another idea that has been discussed is the consideration of helpful services being like a family. This seems very powerful yet people have often come from particularly difficult family backgrounds. Helpful services possibly provide the positive aspects of being in a family that people long for. It is possibly like a substitute family.

Considering most people have experienced loss, rejection, and difficult family experiences, they have understandably developed poor attachments to others. This has made it very difficult for people to form supportive friendships and relationships in society. However, helpful services seem to allow people to experience a sense of belonging.

I am struck by how attachment theory might come into this. In particular, Bowlby's ideas around a hierarchy of attachment figures which the individual can access at times when the primary caregiver is not available. It seems that peer relationships in services might be part of this attachment system so that when the clinician is not available (e.g. out of hours) people feel they have others to turn to for help and support.

July 2010

Although „sense of belonging“ seems an important category and I did consider making this a main category, I have since decided this is a sub-category. Even though this theme has come up in all of the interviews and is certainly a strong theme, it is quite closely linked to feeling validated and not being judged by services and feeling that services accept them and believe in them. This has led me to consider validation and acceptance as the main category and sense of belonging as a sub-category. I think the wider aspect of belonging is feeling accepted and validated and this fits with the participants experiences mentioned in the interviews.

## **Memo 2: Dependency on services**

15<sup>th</sup> May 2010

All three clinician participants interviewed so far have talked about people with BPD being overly-dependant on services and that the services themselves are often to blame. They talk about people often getting into a revolving door dependency where they self-harm in order to receive additional help and that these services provide it. The first participant really talked about people with BPD needing to learn other ways of coping but more importantly that the services themselves need to stop behaving so unhelpfully. He suggested that services actually increased individuals' dependency by reinforcing dysfunctional behaviours such as self-harm. The second clinician participant described CMHTs being particularly difficult since they often promote dependency as there seems to be a lack of understanding about BPD in these teams. She also talked about teams reinforcing behaviours. The third clinician participant has also described dependency as being problematic. He suggested that services were not equipped to work with this client group as these services were not able to provide adequate help for people. He suggested that due to time restraints and the NHS needing to manage symptoms, the deeper relational difficulties could not be tackled so people end up self harming and repeating problematic behaviours. It appears that there is a theme around unhelpful services being ones that react to risks in a problematic way which forms problematic relationships. This seems to be cyclical. I wonder what service users think about this? Do they see their behaviours as being dependent on services or is it the only way people know how to ask for care?

3<sup>rd</sup> June 2010

Many participants have now talked about services increasing dependency for people with BPD. People have talked about the problems with clinicians fearing risks, services not

providing optimal therapy or where people are not supported enough. However, the most striking theme seems to be around a lack of consistency in service responses that increases the dependency on services. It would seem that consistency might reduce dependency but why? Is this to do with attachment?

However, I have noticed that service-users talk about dependency a lot less than clinicians do and it seems like a stronger theme for clinicians. Service-user participants who are more isolated do feel that services are their provider of safety and containment but for others, they did not describe this in such a strong way. There is a sense of real isolation with this client group with very few people they can trust. Services provide the care they want since people often seem unable to access help outside of services (e.g. family/friends) since they have limited social networks. However, when people have been given consistency and a more securely attached service this dependency has not been described.

I am considering how attachment theory might have a role with this. In particular, I am considering infant-caregiver attachment styles and Bowlby's theory around secure attachments. I think this could really fit with this client group.

17<sup>th</sup> June 2010

I have considered making „dependency“ a main category since it seems to be a predominant narrative and has been mentioned over and over again during interviews. However, dependency seems quite closely linked to responsibility and risks in that when services fear risks they promote dependency by being overly-coercive. However, from reviewing the transcripts and considering the coding, I feel these are both different themes and they both possibly need to become main categories.

## Appendix 18: Feedback to participants"letter



### **Borderline personality disorder and helpful service relationships research project**

Dear all,

I would like to take this opportunity to thank you for agreeing to be interviewed for my study and it really was very much appreciated. As you may remember, I was aiming to find out how mental healthcare services were helpful and unhelpful for people diagnosed with borderline personality disorder. I have now finished collecting data for my research and have produced my result based on this. There were differences but also similarities in the views and experiences of those who took part. Below I have summarised the main themes which came out of my interviews. If you would like to feedback or comment on any of the results then please do contact me about this.

I have listed the main themes and their subcategories below explaining a little about each.

### **Summary of findings**

#### **A. Healthy service relationships**

##### **Theme 1: Attachment**

This theme focussed on the experience of having a secure and safe attachment relationship.

##### **Clinicians as safe parental figures**

People talked about helpful services providing a safe attachment relationship. All participants felt it was important for there to be a secure, nurturing attachment in order to explore personal difficulties whilst service-user participants often described helpful clinicians as being similar to ideal parental figures. Once treatment had finished, some participants felt it would be helpful for services to accept people back into treatment if necessary post-discharge. This was felt to be less rejecting and provided more consistency for people.

##### **Establishing trusting relationships**

The importance of services being honest and trustworthy was suggested by most people. There was agreement that longer treatment timeframes were necessary and that people should preferably be seen consistently by the same clinician/service since they had already formed an attachment to that person/service. Some Service-users found it particularly unhelpful if services made false promises or they did not explain their limits of confidentiality well enough.

##### **Consistency in relationships**

Most people talked about services needing to be consistent. This included people seeing the same clinicians over time and for these clinicians to respond in a consistent way. People also felt consistent approaches were required within teams and between services so that inconsistent service responses were reduced. When services were inconsistent people felt they were confusing and rejecting particularly if service-users noticed clinicians responding differently to them compared to other people with different mental health problems.

**Boundaried and challenging clinicians**

Most people felt that having clear and consistently boundaried clinicians or services were helpful in providing a sense of safety. Furthermore, mental healthcare services were the provider of boundaries for people with chaotic lives and who might otherwise be unable to cope. Most service-users also felt it was important to feel well-held but equally challenged by clinicians. They suggested it was unhelpful for clinicians to be too soft and there was a sense of security in people knowing that clinicians were strong enough to cope with any difficulties that arose.

**Theme 2: Acceptance and validation****Sense of belonging**

People talked about the importance of having a strong sense of belonging, inclusion, and acceptance. This was particularly important for individuals who felt most isolated in society and had limited support networks. These participants valued friendships and support in services. Group identity, particularly where self-harm was involved, was helpful for people whilst relating to others with similar difficulties was generally viewed as supportive and educational.

**Being listened to and understood**

Most people felt it was important for service-users to be listened to, understood, and respected. In particular, finding out about people's histories and reasons behind problematic behaviours were identified as helpful.

**Belief and respect in the individual**

Some people described helpful services as ones which showed respect and where clinicians believed in the individual's ability to change.

**Theme 3: Responsibility and risk**

This theme was identified by clinicians during interviews. Although some service-users mentioned this, it was less of a theme amongst these individuals.

**Shared inter/intra service approach**

It was commonly agreed by people that having a shared model of understanding between services, clinicians, and teams was important. In particular, this provided a more consistent and shared approach to risk management that was felt to be supportive for clinicians. It was also suggested that intermittent responses from services reinforced self-harm in service-users and that having a shared understanding would reduce this inconsistency. Where teams did not share a model of understanding it was found to be unhelpful.

**Clinicians taking positive risks**

Clinicians felt it was not helpful to use overly forceful methods when managing people's risks. This included under-reacting to situations (e.g. when someone self-harms) and trying to keep people out of hospital unless absolutely necessary. When hospitalization was necessary clinicians suggested wards should aim at discharging people as early as possible since the wards can be particularly problematic.

### **Giving responsibility to service-users**

People felt services should give more responsibility to service-users for managing their behaviours. It was suggested that this would empower service-users, help them learn to not rely on services whilst reducing their overall dependency.

## **B. Unhealthy service relationships**

### **Theme 4: Invalidation and rejection**

#### **Difficulties being discharged**

Feelings of rejection were identified as particularly problematic by both clinician and service-user participants. For service-users there was a fear of being discharged and not being able to cope without the support gained from services. Most participants also recognised that being discharged might feel rejecting for people with BPD. This was especially so when treatment endings were not handled appropriately by some services, particularly on inpatient wards.

#### **Exclusion and abandonment in services**

A strong theme around people being excluded and abandoned by services was identified. This included individuals being denied therapy, excluded from treatment, and feeling abandoned by clinicians when they had not responded appropriately during crises. Clinicians also recognised that services often excluded people from services based on an individual's diagnosis or because the mental healthcare team was struggling to work with this person.

#### **Sense of being judged and misunderstood**

This theme was shared by most participants. They felt people with this diagnosis were pathologised, judged, or blamed with some services being dispassionate and invalidating of people's difficulties.

#### **Not being listened to (service-users only)**

Some service-user participants found this particularly unhelpful. They felt some services did not listen or try to understand them. This was particularly felt when services seemed rushed and there was a lack of time to talk.

### **Theme 5: Dependency**

#### **Wanting to be cared for by services**

Feelings of dependency and wanting to be cared for by services were identified as problematic mainly by clinician participants. Clinicians suggested that there was often an unhealthy relationship between services and people with borderline personality disorder. For example, an individual might seek help but services may not respond adequately enough or consistently enough so the individual may resort to harming themselves and in doing so, more care is provided but the symptoms are simply patched up rather than helping the individual resolve difficulties. Some service-users were also able to identify their own responses as sometimes falling into this dependency but this was less of a theme.

#### **Isolation and dependency (Service-users only)**

For service-user participants who felt isolated in society and lacked social support there was a stronger theme around dependency on services. When they could not access appropriate help from others, services became their main support system. This was particularly so during crises.

Unfortunately, service responses were often inconsistent so service-users would never know whether they would gain the help that they needed.

#### **Blaming services for dependency (clinicians only)**

Clinicians seemed to agree that services often related unhealthily to people with this diagnosis, making people dependent on services. This included not teaching people skills, services taking responsibility for service-users behaviours, and giving inconsistent responses at times of crises. However, there was recognition that sometimes people's dependency was their way of requesting help from services. Clinicians felt these services were at fault for not attempting to understand the meaning behind behaviours.

### **Theme 6: Symptom Management**

#### **Medication and overmedication**

It was strongly recognised by both clinicians and service-users that medication was often unhelpful in a number of key respects. It was felt that medication only numbed people's feelings rather than helping individuals to deal with the root causes of problems. Participants also suggested that people with this diagnosis were too often over-medicated and sedated as a form of symptom control or risk management and this was very unhelpful.

#### **Patching up symptoms**

Some participants felt that short-term work was inappropriate. It was identified as only patching up symptoms rather than looking more deeply at issues. Brief therapies and only seeing individuals during crises were suggested as particularly problematic. Participants identified that simply managing symptoms rather than relieving people in the longer term was not going to aid recovery. Services with restrictive timeframes were also identified as unhelpful. It was felt un-therapeutic to work with people too briefly as there was not enough time to form a strong enough relationship to work on deeper issues.

### **Theme 7: Disempowerment**

#### **Ward environment and abuse**

Service-user participants who had experienced inpatient settings described traumatising experiences (e.g. aggression, being disliked by staff, or re-traumatised by past experiences of rejection, abuse, or abandonment). Some clinician participants also identified the ward environment as excluding, abusive, un-empathic, and invalidating. There was a general sense that these environments were not particularly helpful and were often quite frightening.

#### **Unhelpful power differences (service-users only)**

Service-user participants felt that having authoritative services that were governed by strict rules were unhelpful. In particular, having a strict patient-doctor relationship whereby clinicians felt they lacked power to influence over their treatment was felt to be particularly unhelpful.

#### **Disempowerment through lack of diagnosis sharing**

A few clinicians felt that rather than colluding with the system the diagnosis should be shared with people in comparison to all service-user participants who really saw the value in being given a diagnosis. They felt it was disempowering to not receive this and for most, this information had not

been shared until recently. Service-users described feeling relieved by having a diagnosis that they could then find out about and learn from other people's experiences of this. In particular, the internet was identified as a helpful source of information. However, most also recognised the inherent diagnostic stigma associated with this label and that this was often felt to be stigmatizing and pathologising.

**Summary of main categories**

Overall the study showed that having a secure attachment to services was important for people with BPD. This included people needing to feel safe and secure in services that emphasized understanding people's attachment difficulties.

This study found evidence that specialist services such as therapeutic communities, mentalization-based therapy (MBT), and dialectical behavioural therapy (DBT) have useful psychological principles for recovery. It is recommended that service managers should consider these models of treating people since they are more containing than service models that do not have a shared understanding, are less collaborative, and are less accepting.

Once again, thank you so much for participating in this study and if you would like to feedback any comments then please contact me directly on .

Yours sincerely,

Rachel Gregory

**Trainee clinical psychologist**



**Appendix 19: Ethics  
summary of research letter**



(chair of ethics committee)

26<sup>th</sup> July 2010

Dear ,

Please find below a brief summary of the following completed research project.

**Study Title:** **Borderline personality disorder and helpful service characteristics: Service-users" and clinicians" views.**  
**REC reference number:** **09/H0807/57**  
**Protocol number:** **2**

The NHS ethical code of conduct was adhered to throughout the study and no major ethical issues arose over the course of this study. None of the participants appeared to be distressed and there were no complaints made or individuals who opted out. Some participants even mentioned that they found the interview a useful and interesting experience. All participants consented to participate in the study and those whose quotations were used in the write-up consented to this.

**Brief summary**

Many assumptions are often made about helpful and unhelpful service relationships for people diagnosed with borderline personality disorder (BPD). The evidence suggests that services that form disorganized attachments to people with this disorder are unhelpful. This included services that reinforce dysfunctional behaviours through coercive measures (e.g. hospitalising people) and when people with BPD form overly-dependent relationships with services, lacking responsibility for their behaviours as the service holds this responsibility. Research evidence suggests helpful services are those that provide a secure attachment that uses psychological principles such as validation and acceptance, giving responsibility to service-users, and services which are consistent, cohesive and share a model of understanding.

A grounded theory approach was used to analyse the data from one to one semi-structured interviews carried out with qualified mental healthcare clinicians who had experience of working with people with BPD and service-users formally diagnosed with BPD. Sixteen individuals participated; 8 clinicians from diverse backgrounds (e.g. psychiatry, nursing and psychology) and 8 service-users with BPD from community mental health teams, a therapeutic community, and inpatient unit.

The results suggested that helpful service relationships were ones where services formed secure attachments to people (e.g. secure and caring attachment, acceptance and validation, and

responsibility). Unhelpful services were those that formed insecure attachments (e.g. invalidating and rejecting, dependency, symptom management, and disempowerment).

Secure attachment refers to the sense that services provide a safe and containing environment with clinicians identified as safe parental figures who are both boundaried and adequately challenging. Such relationships need consistency, trust, and honesty. Acceptance and validation includes people with BPD feeling they belong within a group and are accepted within services. This includes being listened to and understood whilst being respected and believed in. Responsibility and risk was a theme that only clinicians fully referred to. This included the importance of having a shared service model of working, particularly when considering risk issues. Clinicians considered it important for them to be able to take positive risks and for more responsibility to be given to service-users.

Unhealthy relationships included those that were Invalidating and rejecting. These service relationships showed difficulties around rejection when people were discharged whilst some services excluded people and others did not listen to service-users, misunderstood, and judged people with BPD. Dependency refers to wanting to be cared for by services, particularly for those who were most isolated in society. Clinicians blamed services for making people overly-dependent and for not taking responsibility for this. Symptom management includes issues around medication not helping people and over-medication being used to sedate people rather than exploring relational difficulties. This was seen as patching up symptoms where brief interventions were found to be particularly unhelpful since a trusting and consistent relationship could not develop. Disempowerment referred to certain environments being abusive and disempowering (e.g. ward environment) whilst service-users identified unhelpful power differences between them and clinicians as unhelpful particularly when they were authoritative and rigid. Also, people described feeling empowered when their diagnosis was shared with them but felt that services still were not disclosing this with people.

A model based around attachment theory was developed and this study concluded that services which emphasize understanding people's attachment difficulties and which promoted a secure relationship were helpful for people with BPD.

Yours sincerely,

Rachel Gregory  
Trainee clinical psychologist

**Appendix 20: Journal of Personality Disorders, notes for contributors**

[Home](#) » [Journals & Newsletters](#) » [Psychology](#)

**Journal of Personality Disorders****Official Journal of the International Society for the Study of Personality Disorders**

Edited by Paul S. Links, MD, MSc, FRCPC  
University of Toronto

**Instructions To Authors****Types of Articles**

**Regular Articles:** Reports of original work should not exceed 20 pages (typed, double lined spaces and with standard margins, including tables, figures, and references).

**Invited Essays and Special Articles:** These articles provide an overview of broad ranging areas of research and conceptual formulations dealing with substantive theoretical issues. Reports of large scale definitive empirical studies may also be submitted. Articles should not exceed 30 pages including tables, figures, and references. Authors contemplating such an article are advised to contact the editor in advance to see whether the topic is appropriate and whether other articles in this topic are planned.

**Brief Reports:** Short descriptions of empirical studies not exceeding 10 pages in length including tables, figures, and references.

**Manuscript Preparation and Submission:** Manuscripts must be typewritten, double spaced, prepared for blind review, and submitted along with a cover letter to the Journal's Editor via email to the Editorial Office at [ezardd@smh.toronto.on.ca](mailto:ezardd@smh.toronto.on.ca). All articles should be prepared in accordance with the Publication Manual of the American Psychological Association (5th. Ed.), (e.g., they must be preceded by an abstract of 100-150 words and adhere to APA referencing format).

Email enquiries may be directed to Debbie Ezard at: [ezardd@smh.toronto.on.ca](mailto:ezardd@smh.toronto.on.ca).

**Appendix 21: Independent review approval letter**

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